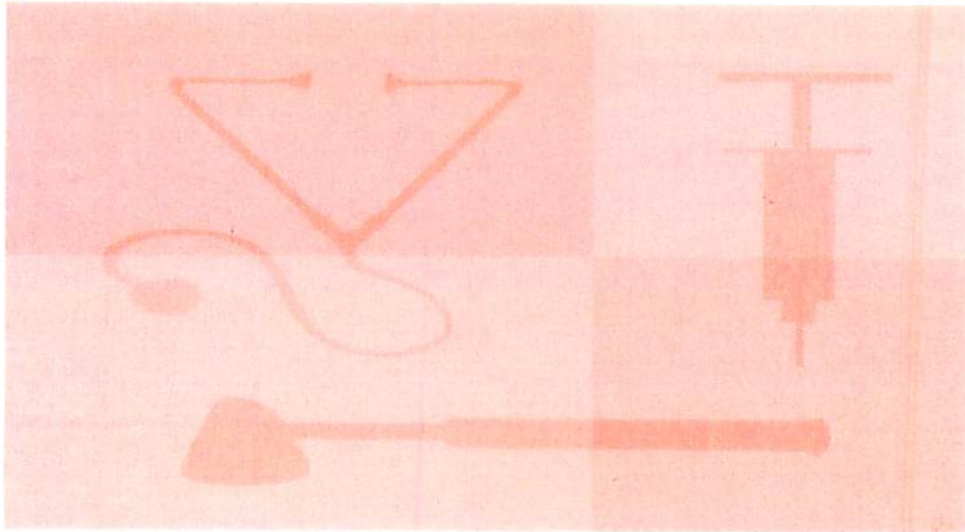

Best Practice Guidelines

General Guidelines for Nursing

Division of Mental Retardation Services

Department of Finance and Administration

State of Tennessee

2002

Nursing is complex and is expanding its professional roles to meet the needs of the changing health care system. Nurses practice in diverse settings, in many roles within those settings, and with other care givers in the allied health professions. The regulation of safe and competent nursing practice is monitored through the licensure process and the specific laws within each state. Certain standards of practice are important as guidelines for nurses to provide care and as criteria for evaluating care. When standards are clearly defined and followed, individuals can be assured they are receiving high-quality care. Internal standards are established by a nursing department. The following guidelines are an effort to implement and improve standards of nursing within the Division of Mental Retardation Services. A nurse assumes responsibility and accountability for all nursing care delivered. Regardless of educational preparation and experience, nurses are expected to perform competently. The following guidelines will assist every nurse within the Division by establishing a state-wide standard of practice for each area discussed. The sharing of these guidelines is prohibited outside the realm of the Division without permission.

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Division of Mental Retardation

March 2002

Best Practice Guidelines

Documentation

Special points of interest:

- General Guidelines for Nursing Documentation
- Anticipated Outcomes
- Specific Focal Points
- Points to Ponder

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Section I. Overview:

Documenting nursing care in the person's medical record is an essential and necessary part of care. Nursing care must be a complete and accurate account of care rendered. The contents of the medical record are regulated by many sources including, licensing, accrediting, and professional organizations; for example, the American Nurses' Association standards, case law, and state nursing practice acts. Common requirements from those sources include, but are not limited to:

- ✓ Medical history
- ✓ Physical examination reports
- ✓ Reports of laboratory and other diagnostic tests,
- ✓ Nursing (Health Care Assessments) assessments
- ✓ Care provided
- ✓ Informed consent for procedures/treatments
- ✓ Teaching

Document any assessment.

Anticipated Outcomes of Documentation

1. All individuals served by the State of Tennessee Department of Finance and Administration Division of Mental Retardation Services (DMRS) will have their health needs clearly identified. The progress and response to all health services shall be evident in a written note. The format for the note may be determined by the facility; for example, a written Progress Note, as used in the Developmental Centers; a Daily Staff Note, as used in the Community; a Nurses Progress Note, as used by Nursing Staff.

2. Documentation will provide a measurable means of assessing and evaluating the care of the individual. The care of the individual will focus on the person's needs, capabilities, limitations, and problems. The content of the note must contain appropriate information to include subjective information, objective information, assessment or analysis, and a plan including follow-up as appropriate.

3. Documentation will serve as a reliable source of information. Documentation will be an effective means of communication to all staff members involved in the care of the individual.

A. Uses of documentation

1. Continuity-of-care tool

√ Documentation coordinates health care and improves its quality. Typically, individuals with developmental disabilities have several nurses, primary care providers, pharmacists, therapists, case managers, and unlicensed personnel who provide care. With such a large multidisciplinary team, accurate documentation may be the person's only protection against fragmented and possibly dangerous care.

√ The person's medical record usually contains:
- An information sheet identifying the demographic data
- Medical information
- Medical Treatment Plan
- Health related documentation
- Health Care Plan
- Medication administration records
- Laboratory and diagnostic test results

Keep organized records.

√ The medical record must tell the entire story of the person's condition and care. All health care providers who read the record must be able to understand the person's care and needs. The record must also make sense to others who might review it, such as attorneys, peer reviewers, regulatory bodies, etc.

2. Person protection device

√ Documentation creates a record of actions taken to protect the person from harm. These actions may include notifying appropriate people of changes in the person's condition and describing events that threaten their well being.

3. Quality management aid

√ Medical records provide information about care practices and related problems. By reviewing records, quality management staffs members (peer reviewers) can identify trends in care and obtain the data needed to investigate specific quality concerns.

4. Legal safety net

√ The medical record is a legal document. Each person that writes in the medical record is responsible for the information he or she records if called as a witness to testify concerning information written.

√ Documentation provides crucial legal protection. Admissible in court, the person's medical record must be documented in an accurate, complete, systematic, logical, concise, and timely manner. Courts view the medical record as verification of care. In their eye's, **what is not documented did not occur**.

√ The medical record is also used in litigation in which professional negligence is alleged (and is the first piece of potential evidence extensively evaluated by the plaintiff's attorney when consulted in a suit). Therefore, it must be viewed as a viable way in which to defend against allegations of professional negligence. If the medical record is complete and accurate and reflects the documentation of high-quality, non-negligent care, it can be the nurse's "best defense" against allegations of negligence. If, however, the documentation is incomplete, contains gaps, is not consistently done following guidelines, and is inaccurate; the record can, and will be used to support the allegations of negligence in the complaint.

B. Criteria for legally defensible documentation

1. Write legibly.
2. Use black, permanent ink for entries. Do not use colored pens, pencils, or felt-tip pens.
3. Date and time all entries.
4. Account for every entry, that is the nurse must sign his or her name and list credentials and other required data for every entry reflecting care. **No nurse shall document for another person.**
5. No blank spaces shall remain in any area of the documentation. If space remains on a line after the entry is complete; the nurse should draw a line through the space to the end. If larger areas are available on form sheets (e.g., comment section, or other sections) are not used; draw a line diagonally through them. This clearly indicates unquestionably documentation in the section. Documentation like N/A (for not applicable or not assessed), if documentation policies allow is acceptable.
6. There should be no erasures, obliterations, or "whiting out" on any portion of the medical record. If an error in the record must be corrected, it should be done by drawing one line through the error, initialing and dating the line, and continuing the documentation of the correct information on the next available space or line.

Use Ink.

What you write may go to court.

7. Factual entries are essential. The medical record is no place for opinions, assumptions, or meaningless words or statements ("Had a good day"). Rather, the entry should be factual, complete, accurate, and contain observations, clinical signs and symptoms, direct quotes, if applicable, interventions and person's response.
8. The use of correct spelling, punctuation marks, and grammar is important.
9. Every medical record sheet should reflect the person's correct name and identification number, if applicable.
10. Use only adopted abbreviations through out the DMRS system. Restrict abbreviations, if used, to ones adopted by DMRS system only. The nurse must not use his or her own abbreviations, however clever or time saving they may be.
11. Documentation in the record should occur as soon after the care is given as possible. **Never make an entry before a procedure or medication is given.**

Criteria for legally defensible documentation continued:

12. When a primary care provider (PCP), supervisor, or others (including other nursing staff) must be contacted concerning the person's condition, that information should be entered in the record in a factual and accurate manner. It must include the manner of communication, the names of those contacted, a summary of the discussion, and what response took place as a result of the contact. Documentation of new orders, the care provided, the person's response to the newly ordered care, and any other necessary information must follow policy. Completion of an incident or occurrence report may also be necessary.

13. Do not countersign any order, control drug count, narrative entry, or other documentation unless the countersigned can attest to the accuracy of the information and that he or she has personal knowledge of it. If a nurse cannot speak to both of those issues, it is best to qualify the countersignature in some way; for example, documenting that the nurse has only reviewed the entry and signed it.

14. Document in the person's medical record when an unusual incident occurs, such as a fall or other type of injury, in addition to documenting the information on an incident report. The filing of an incident report ***does not*** take the place of documenting the information in the record.

15. When a person leaves the nurse's care (for diagnostic work) or the nurse leaves the person (when a nurse leaves the home after provision of care), an entry in the medical record must occur. It should reflect the time, the condition of the person upon leaving, and any other information necessary for which the reader of the entry must be aware.

16. A person transfer requires documentation in the record. Information concerning the transfer must including the date and time of transfer, person's condition when transferred. It must also reflect who (if anyone) accompanied the person, who provided the transportation, where and to whom the person is transferred, and the manner of transfer (e.g., wheelchair, ambulance) be documented in the record.

Documentation is important.

17. Document the consent for, or refusal of treatment in the record. Documentation is either by written consent or refusal forms or by the PCP documenting this information in his or her progress notes. If the nurse is involved in a consent or refusal situation, document the incident in the nursing notes.

Document every opportunity for teaching.

18. Document the person/caregiver/family teaching, as well as discharge planning in the medical record. The use of teaching forms for purpose of documenting the teaching is an acceptable way of doing so, as long as the forms can withstand legal challenges to their completeness, accuracy, and the person/caregiver/family's ability to understand them. Likewise, discharge planning must be complete, specific to the needs of the person/caregiver/ family, and communicated to all responsible for the person's care.

19. Document in the record the existence and disposition of any of the person's belongings; e.g., dentures, glasses, jewelry, and money.

Criteria for legally defensible documentation continued:

20. Document the person's responses to medications, treatments, teaching, and any other interventions by the nursing staff. It ***is*** important to intervene with a health care concern/problem. However, it is equally important to assess and document the person's response to the care provided.

21. Adhere to and review regularly the agency or institution policies when documenting in the person's record.

22. When it is necessary to add omitted information to an already existing entry, policies and procedures should conform to them. Most often, the addition of information is coded on the next available line or space as a "late entry" or "addition to nursing note of _____," given the date and time of the information that is being added and then placed in the record.

Possessions are important.

Points to Ponder

MEETING BASIC DOCUMENTATION GOALS

When recording care, use the checklist below to determine if the three basic goals of documentation are met.

1. Accurately describe the person's condition and progress.

- ❑ List initial assessment data.
- ❑ Identify potential and actual problems.
- ❑ Detail the procedures, treatments, and drugs administered.
- ❑ Describe the person's responses to procedures, treatments, and drugs.
- ❑ Delineate teaching, including topics covered and evaluation of learning.
- ❑ List health care actions.
- ❑ Name the people notified of the person's condition.

2. Communicate clearly, using specific, objective language

- ❑ Give exact times and dates for assessments, interventions, and other events.
- ❑ State the **facts** in a straightforward manner.
- ❑ Quote the person (others) directly when appropriate.
- ❑ Describe only what you've seen, heard, smelled, and touched.
- ❑ Avoid **assumptions** and **personal opinions.**
- ❑ Use only standard abbreviation (if used at all) and correct spelling.
- ❑ Make handwriting neat and legible.

3. Satisfy legal requirements

- ❑ Write and, if necessary, correct documentation properly.
- ❑ Be accurate and truthful.
- ❑ Allow no omissions, blanks, or unused spaces.
- ❑ Note all communication with other care providers.
- ❑ List all assessment findings and nursing actions.
- ❑ Do not refer to documents that are not part of the medical record, such as incident reports.
- ❑ Include signature and the date as well as time, when appropriate.

C. Use of abbreviation

Restrict abbreviations, if used, to ones adopted by DMRS system only. The following appear in the ***MEDICATION ADMINISTRATION FOR UNLICENSED PERSONNEL*** text .

ABBREVIATION	ENGLISH MEANING
a‾	before
a.c.	before meals
ad lib	freely as desired
a.m.	before noon; morning
aq.	water (e.g. dilute in water)
as	left ear
ASA	aspirin
ASAP	as soon as possible
au	both ears
b.i.d.	twice a day (in 24 hour period)
buc.	buccal route
c‾ or w/	with
cap or caps	capsules/s
cath.	catheter
c.c. (ml)	cubic centimeter
c/o	complains of
d.	day
D/C or disc.	discontinue
dil.	dilute or dissolve
dr.	dram
dx	diagnosis
elix.	elixir
exp.	expiration
ext	extract
F	Fahrenheit
fld. ext.	fluid extract
GI	gastrointestinal
gm/GM/g	gram
gr/GR	grain
GTT/gtts	drops
GU	genitourinary
h.	hour
h.s.	hour of sleep
lb	pound
mg/mgm	milligram
ml (c.c.)	milliliter
n.p.o.	nothing by mouth
O.D.	right eye
oint.	ointment
ophth.	ophthalmic
O.S.	left eye

ABBREVIATION	ENGLISH MEANING
otic	pertaining to the ear
O.U.	both eyes
oz.	ounce
p‾	after
p.c.	after meals
per	by
p.m.	afternoon; evening
p.o.	oral (per os); by mouth
p.r.	per rectum
p.r.n/P.R.N.	as needed
q.	every
q.d.	every day (abbreviation not recommended, use daily or q. day)
q.h.	every hour
q.2h.	every two hours (any # can be used)
q.i.d.	four times a day (in a 24 hour period)
q.o.d.	every other day
(R)	rectal route
s‾	without
sol.	solution
STAT	immediately; now
Subl./SL./Subling.	sublingual
supp.	suppository
syr.	syrup
tab.	tablet
tbsp.	tablespoon
tsp	teaspoon
t.i.d.	three times a day (in a 24 hour period)
tr./tinc.	tincture
u.	unit
ud	as directed
ung./oint.	ointment
wa	while awake
w/o	without
x	times

CHEMICAL ABBREVIATIONS

ABBREVIATION	MEANING
Fe	Iron
HCl	Hydrochloric Acid
H_20	Water
H_20_2	Hydrogen Peroxide
KCl	Potassium Chloride
KI	Potassium Iodide
MOM	Milk of Magnesia
Na	Sodium
NaCl	Sodium Chloride

LIQUID MEASUREMENTS

HOUSEHOLD	APPROXIMATE METRIC
1 teaspoonful	5 ml
1 tablespoonful	15 ml
2 tablespoonfuls	30 ml
1 measuring cupful	240 ml
1 ounce	30 ml
1 pint	480 ml
1 quart	960 ml

PARENTERAL ROUTES OF ADMINISTRATION

ID	Intradermal
IM	Intramuscular
IV	Intravenous
SQ or Sub Q	Subcutaneous

D. Methods of documentation

For the nurse to perform expertly, an organized approach must be taken to documentation that promotes accurate, rapid record keeping. Two major systems –source-oriented and problem-oriented documentation have been used over the years. Others include the traditional narrative note system that now usually is combined with another format, and newer systems, including focus charting, problem-intervention-evaluation charting and, charting by exception. The various methods of documenting are listed below.

1. Source-oriented documentation

✓ In source-oriented documentation, each professional discipline keeps separate records. For instance, nurses record in nursing notes and physicians write progress notes. This means the reader must consult several sources to get a complete, accurate picture of the person's condition and care. If this system is used the nurse must take extra steps to communicate the person's information to other team members.

2. Problem-oriented documentation

✓ The purpose of problem-orientated documentation is to aid communication among team members. Based on assessment findings, team members care create a problem list, formulate an initial plan of care for each problem, use multidisciplinary notes, and write a summary that tells whether each problem was resolved. Typically routine assessment and care is recorded on flow sheets.

✓ Problem-oriented progress notes are organized by the acronym **SOAP**:

SOAP

- **S**ubjective data—what the person or others say (not observable or measurable)
- **O**bjective data—information gathered through physical examination, clinical measurement and/or diagnostic testing
- **A**ssessment—analysis based on subjective and objective data
- **P**lan—actions to be implemented based on SOA data

Additional acronyms may be added

- **I**mplementation—of interventions and treatments
- **E**valuation—person's response
- **R**evision—changes to interventions as needed based on evaluation.

Newer versions eliminate subjective and objective and start with assessment—a combination of subjective and objective data. Thus, the new acronym is **AP, APIE, or APIER**.

3. Narrative notes

✓ Narrative notes record assessment data, interventions, and person responses in a straightforward, chronological form. Often narrative notes are reverted to in emergencies or unexpected situations because the system is easy and flexible enough to use in virtually any care setting. However, when narrative notes are used as the primary documentation method, they have major disadvantages:

- They reflect the author's subjective viewpoint.
- They do not allow easy tracking of problems and trends.
- They complicate information retrieval.
- They make care appear disorganized.
- The can be repetitive and time-consuming.
- They do not always reflect the nursing process.

Methods of documentation continued:

4. Focus charting

- ✓ Focus charting identifies person-centered concerns. A focus may be a nursing diagnosis/analysis, a sign or symptom, a behavior, a special need or an acute change in the person's condition. Notes are organized according to the **DAR** framework:
  - **D**—stands for person assessment data
  - **A**—stands for actions or interventions taken
  - **R**—stands for the person's response
- ✓ Focus charting highlights person concerns, incorporated aspects of the nursing process, and can be adapted to any clinical setting. However, writing accurate, logical notes using this system, particularly in long term care settings, can be challenging.

E. General documentation of care

Every time there is documentation of an assessment finding, intervention, or topic taught, the documentation is helping ensure the most effective treatment for the individual. Documentation is the best protection the individual, team, and health care provider have. If you fail to record documentation, from a legal standpoint it was never provided.

1. Documentation and quality of care evaluation. Documentation in the record should clearly reflect the evaluation and the response to nursing care measures.
2. Organizing data. Organize the information into logical categories.
3. Document what the person tells you. Information gathered serves as the basis of the teaching plan. All these facts help the team identify successful treatments to include in the management plan.
4. Document what you assess. Be objective, specific and concrete. Use objective language and avoid making judgments. Describe only what you see, hear, feel, and smell during the assessment.
5. Document what you do. Documentation should show that the appropriate actions were taken based on the assessment of the individual. Document the individual's response. Document referrals made and their outcomes.
6. Document what you teach. Clearly indicate the understanding of the instructions provided by the individual as well as the caregiver.
7. How documentation helps evaluate the plan of care. Documentation helps to evaluate the plan and revise it as needed.

F. How to document a telephone or verbal order

Telephone and verbal orders are easily misunderstood. Specify the circumstances under which a professional provider may give telephone or verbal orders and require the professional provider to cosign the orders within 24 hours.

Implement telephone orders correctly.

Do not accept a telephone or verbal order unless the professional provider has a valid reason for giving one. When such an order is necessary, repeat the order back to the professional provider using his or her exact words. Review your notes to make sure all the information is present (drug, dose, time, route, person, texture, position). Ask for clarification as needed, including the correct spelling of the drug. If possible have a colleague verify the telephone order by listening on a second extension and cosigning the order on the order sheet.

Write the order on the physician's order sheet. Record the date and time and note whether it was a telephone or a verbal order. Write your full name and credentials, and have the colleague who verified the order write his or her name after yours. Make sure your notes indicate that you carried out the order and report the assessment.

G. How to correct a mistaken entry

Make sure that the information written in the individuals record belongs there. Occasionally an honest mistake is made in an individual's record. Correct a simple error to show that you have taken ownership of the mistake and are not hiding anything. Specify the reason for the mistake.

For a more serious mistake, consult the facility's risk manager for instructions. Also inform the health care team members of the error so they can reevaluate the person's treatment plan as needed.

An honest mistake must be corrected.

Points to Ponder

CORRECTING A MISTAKEN ENTRY

When correcting a person's medical record, follow the general guidelines below as well as internal policies and procedures.

Do's

- ✓ ***Do*** draw a single line through the mistaken entry so the original words remain visible.
- ✓ ***Do*** write "Mistaken entry" above or next to the original words to explain when the line was drawn.
- ✓ ***Do*** write initials and the date and time next to the words "Mistaken entry".
- ✓ ***Do*** follow the proper procedure for making a late entry if information must be added.

Don'ts

- ✓ ***Don't*** try to squeeze corrected information around the original entry.
- ✓ ***Don't*** use correction fluid, draw thick line through the mistaken entry, or otherwise make the original words unreadable.
- ✓ ***Don't*** write "Error". Juries tend to associate this word with a clinical error that led to a person's injury.
- ✓ ***Don't*** try to hide your mistake. If the jury suspects that something is hidden, it is likely to find against the writer even though they did nothing wrong.

H. How to make a late entry

No rules prohibit documenting out of chronological order. A late entry is better than no entry. Occasionally there is a need to postpone documentation while attending to a critically ill individual. All pertinent information is very important. Be aware that an unusually long period of time between care and the documentation could raise the suspicion that the late entry may be hiding a problem. Follow the facility's policy on making late entries. How you explain and format the entry depends on the circumstances.

⇒ Start the entry with the date and time it is written. Within the note record the time of the event being described.
⇒ Do not insert information in the margin or on top of an existing note. Start the late entry on the next available line.
⇒ Label the entry "Late entry".
⇒ Document the reason the note is written out of sequence. Note the date and time the entry should have been written.
⇒ Make the entry as legible as possible.

I. How to write monthly summaries

- ✓ Most long-term-care settings require nurses to write a monthly summary of each person's general condition. Although this practice requires the nurse to document care and observations that you did not give or witness, it is legal as long as it is labeled as **"Monthly summary of the medical record."**

- ✓ In this situation, the nurse's signature indicates only that he or she has read and summarized the notes from all nursing entries/shifts. It does not indicate that the nurse is personally attesting to the information. On the other hand, if the nurse documents the observations and care in the note as his or her own, they *could* be held responsible for the information. Hence, the summary must be labeled as such.

Monthly summary of the medical record...

J. When a nurse is asked to countersign another nurse's notes

Countersigning another's notes means that you are attesting to their truthfulness and accuracy. Review the facility policy on countersigning. Never countersign notes that you have not read. Read the entry carefully for accuracy, logic, misspelled or misused words. Make sure the entry clearly identifies who performed the procedure and exactly what was done. If the entry suggests or describes a problem that requires follow-up action, make sure the action has been taken. If your countersigned signature means that the care and findings described were observed, then consider adding a disclaimer before your signature.

Points to Ponder

WRITING A DISCLAMER

It is advisable that the nurse write a disclaimer in front of their countersignature. Keep in mind that the disclaimer does not extend to subsequent signatures. A new disclaimer must be written each time that the signature is countersigned.

Types of disclaimers

- ✓ If the countersignature means only that the nurse reviewed a colleague's note, the disclaimer should read:

  Jane Smith, LPN/Entry reviewed by Susie Snow, RN

- ✓ If the information is verified in the entry, the nurse should write:

  Jane Smith, LPN/Entry verified by Susie Snow, RN

- ✓ If the information cannot be verified in the entry, write a disclaimer such as:

  Signed in accordance with policy. Signature does not indicate personal knowledge of the information above charted by Jane Smith, LPN. Susie Snow, RN

- ✓ If the nurse participated in the care, a disclaimer is not needed. The nurse countersigns a follows:

  Jane Smith, LPN/Susie Snow, RN

K. How to document care given by unlicensed personnel

Review the facility policy on documenting care given by unlicensed personnel. If the documentation means that you have witnessed or can verify the care by the unlicensed personnel, try to substantiate the reports from the unlicensed personnel by conducting interviews and spot checking. Interview the individual or family members about the care received. Then record only what the unlicensed personnel and the individual or the family can verify. If there is doubt of the accuracy of the information, investigate further before signing and recording the entry.

In the nurse's notes, record the name of the unlicensed personnel who provided the care you are documenting. Clearly distinguish what was reported to you from what you have verified. When documenting vital signs that the unlicensed personnel measured, be sure to record the name of the unlicensed personnel.

L. How to document communication with other care providers

- ⇒ Record what you said, not just what you did.
- ⇒ Always document that pertinent information was reported to the health care team members, along with the time of notification and the individuals name and response.
- ⇒ Note that findings were communicated to the physician.
- ⇒ Record the interventions the physician orders.
- ⇒ Documenting notification time establishes the interval between the assessment and the report of those findings, helping show that you notified the physician promptly.
- ⇒ Record communication with other health care team members.
- ⇒ Document every conversation you have with other health care team members.

Communication is important.

Section II. Documenting difficult situations:

An individual may refuse a specific procedure. The right to refuse treatment is linked to the rights to informed consent and privacy. The right of refusal of treatment also serves as the basis of advance directives. If an individual refuses treatment, review your facility's policies and procedures to determine under which circumstances the refusal may or may not be honored. Respect the wishes of the individual.

A. How to document refusal of treatments, medication, etc.

1. Types of refusals.

- √ Express refusal, which can be verbal or written, is the clear statement by the individual that he or she is unwilling to have treatment. A written refusal usually takes the form of an advance directive, or the release-from-liability form.
- √ Implied refusal is expressed by actions rather than words. The individuals conduct indicates the implied refusal.

How to document refusal of treatments, medication, etc. continued:

2. Reasons for response.

- √ Refusal may be due to lack of knowledge of the medical condition
- √ Refusal may be because of misunderstanding of the treatment benefits or risks
- √ The treatment may conflict with personal, cultural, or religious beliefs
- √ Refusal may be linked to legal or clinical incompetence

Respect the persons right to refuse treatment.

3. How to respond.

- √ Respect the individuals right to refuse
- √ Do not threaten or scare the individual into accepting treatment
- √ Ask why they are refusing
- √ Provide teaching if the refusal indicates lack of understanding
- √ Notify the physician of the refusal
- √ Consult the physician for the appropriate plan of action
- √ Continue to provide the necessary care the individual will allow

4. Obtaining informed refusal.

Responsibility to obtain informed refusal rests with the physician. Be sure to document informed refusal in the medical record. Informed refusal is a written statement acknowledging the individual has received an explanation of the treatment, reason for the treatment, and risks of not having the treatment.

5. What to document.

Treatment refusal must be documented carefully to prove that you did everything possible to protect the individual from harm while protecting their rights. Complete an incident report clearly detailing everything if required by the facility. Recording treatment refusal may include:

- ⇒ Date and time of refusal
- ⇒ Specific treatment refused
- ⇒ Names of persons who witnessed decision and their relationship to the individual
- ⇒ Individual's physical and mental status at time of refusal
- ⇒ Drugs or treatments completed by individual in 2 hour period before refusal, and reaction to them
- ⇒ Presence and condition of medical equipment or devices being used by individual
- ⇒ Statements made to individual and his or her response
- ⇒ Names of the physician, administrator, and others notified; times of notifications; content of the discussion; actions in response to notifications
- ⇒ Notation of refusal to sign consent or informed refusal form
- ⇒ Notation of existence of an advance directive

Points to Ponder

THE PERSON'S RIGHT TO REFUSE TREATMENT MAY NOT BE HONORED IF:

- ✓ The treatment is for a communicable disease that threatens the life or health of others
- ✓ An innocent person may be harmed
- ✓ The treatment would prevent the death of a person who is not terminally ill

- ✓ The refusal is from a minor (who is not legally permitted to refuse treatment)
- ✓ The refusal violates DMRS ethical standards.

B. How to deal with the person who is noncompliant

- Review diagnostic test results and other evidence that supports suspicion of noncompliance.
- Discuss results with individual.
- Remain nonjudgmental and avoid accusations.
- Ask individual if they are following treatment plan.
- Treat response respectfully, they have the right to refuse treatment.
- If necessary, try to adjust the plan to better meet the needs of the individual.
- Reinforce the rationale for the treatment plan and the importance of complying with it.

What to document.

- √ Data used to evaluate noncompliance, date data obtained
- √ Content of discussion with individual
- √ Individual's reason for noncompliance
- √ Teaching provided about plan, importance of plan, consequences
- √ Copies of written materials provided to individual
- √ Note individual's understanding of teaching provided
- √ Objective and subjective findings of physical and mental status assessment
- √ Treatment plan changes to improve compliance
- √ Communication with other health team members
- √ Complete incident report as required

Document noncompliance.

Points to Ponder

COMPLIANCE VERSES ADHERENCE

- ✓ *Compliance:* Refers to acting in accordance with orders or giving in to others' demands. It implies obedience.
- ✓ *Adherence:* Refers to continuing an agreed-upon treatment under limited supervision. It implies active participation and willing cooperation.

In your documentation, indicate that you established a partnership with the person you serve. Do not merely state that he or she is noncompliant. Instead, describe specific parts of the treatment plan he or she has or has not complied with. Use words such as "adhere to" and "follow" instead of "comply".

C. When the person doesn't understand the procedure

The physician is responsible for providing information about a treatment or procedure. It is the responsibility of the nurse to make sure the individual understands that information. If the individual does not understand, he or she can not give informed consent. Try to attend when the physician explains or clarifies the treatment or procedure.

If the individual asks you about the treatment or procedure, answer those questions to the best of your ability. Determine understanding by evaluating the responses of the individual. Uphold the individual's right to have informed consent.

Document the conversation that led to the belief that there was lack of understanding of the planned treatment or procedure. Document that you conveyed this belief to the physician. Document the response from the physician. If there was additional information to the individual, document the conversation, the understanding and the giving of informed consent.

D. When equipment fails

Medical equipment must work properly. Equipment failure may result in a life threatening event. Assess the situation. If there is immediate danger call for assistance and start emergency interventions immediately. Notify the physician immediately. Follow policy and procedure for tagging equipment and filing of an incident report.

If the equipment failure does not pose an immediate danger, notify the physician of the incident, the assessment findings, and follow through on the physician instructions to correct the situation. Obtain replacement equipment quickly. Follow policy and procedure for tagging equipment and filing of an incident report.

Document model, brand name, serial number of failed equipment.

Document in the nurses' notes:

- √ how the equipment failure was discovered
- √ description of the problem
- √ the steps taken to prevent injury to the individual
- √ how the physician was notified
- √ when the physician was notified
- √ the physician's instructions
- √ the time the instructions were implemented
- √ the individual's response to the interventions
- √ an assessment of the individual's condition
- √ appropriate replacement or repair of the equipment
- √ document the brand name, model, and serial number of the failed equipment
- √ any conversation with the individual about the faulty equipment
- √ required reassessment and the times for the assessment

Replace or repair faulty equipment.

E. When the person's belongings are missing

Every individual is entitled to have personal belongings. Follow policy and procedure when an item is reported missing. Ask the individual to recall when they last had or saw the item in question. Help the individual search for the item. Ask staff and family to help locate the item. Check with the lost and found department if one is available. Document attempts to locate the missing item. Show that the staff treated the incident with concern and caring. Complete an incident report as required by policy.

When documenting a missing item:

- Date and time of reported disappearance
- Description of item
- Time and place item last seen
- Name of person who last saw item
- Names of others questioned
- Places searched
- Names and times of administrative personnel notified
- Action taken by administrative personnel
- Individual's response to incident

F. When the person's family questions the person's quality of care

Take all questions seriously. Never dismiss or ignore the question. Ask why they believe there has been a lack of quality care. Clarify their concerns to make sure there is an understanding of the concern. Answer honestly, do not provoke anger. Provide teaching or clarification if there is misunderstanding. Refer questions to the physician, risk manager or advocate to make sure questions are answered.

Document the questions and concerns. Document the names of the family members, the physician, nurse administrator, or others present during the discussions of the quality of care. Document what you, the physician, and other staff members told the family. Keep the documentation objective and use direct quotes when possible. File an incident report as needed if there has been a lack of quality care.

Section III. Handling difficult professional issues

A. When a colleague illegally alters the medical record

Keep the medical record relevant. Write information in the record that belongs there. Do not tamper with the record. Use appropriate forms provided by the facility to record complaints about understaffing, instances of conflicts with a colleague, reports of questionable nursing care.

Has someone altered the medical record?

Actions that constitute tampering include:

⇒ Improperly adding to someone's notes
⇒ Destroying all or part of an individual's medical record
⇒ Rewriting all or part of a record
⇒ Omitting significant facts from the record
⇒ Deliberately documenting inaccurate material
⇒ Falsifying an entry or adding to an entry without indicating that the addition was a late entry or an addition to an entry

Do not change the nursing notes because they conflict with a physician's or colleague's notes. Trust that your notes will support your documentation. Always document the time that you make an entry. Do not use a blanket time such as "first shift" or "7-4 shift". As required complete an incident report describing the conversation with the coworker who altered the record or requested that you do so. In the incident report note the times you made documented entries in the medical record.

When an honest mistake is made in the record, take ownership of the mistake and record it as a "mistaken entry".

B. When an inappropriate comment is found in the medical record

Every individual has the right to refuse prescribed interventions. The medical record should simply describe the actions of the individual, your response, and any actions taken to ensure delivery of competent care. Do not criticize the individual, family members, or other staff for their actions.

When you discover an inappropriate comment in the medical record notify the appropriate administrator. It is up to the administrator to investigate and address the comment. The administrator has the responsibility to explain to the person who wrote the note the proper method for addressing an individuals noncompliance.

Complete the appropriate form according to policy and procedure. If appropriate send a message to the administrator concerning the entry. The administrator can suggest training on documentation for all staff members.

Points to Ponder

A nurse administrator can *legally* alter a medical record after reading an inappropriate comment. This alteration provides legal protection, showing that he or she took steps to ensure the quality of the individual's care and promoted cooperation among employees. The administrator should also explain his or her actions to the staff member who made the comment.

The nurse administrator crosses out the comment with a single line, writes the date and time, and initials the original note. The administrator asks the staff member who wrote the inappropriate comment to initial the alteration.

C. When a medical record is removed from the center/home

When a health care professional states that he or she is removing the individual's medical record from the facility or home, remind him or her that this is not permitted. Offer to copy the portion that is needed, and record the names and dates of the sections that were copied.

Keep in mind that most facilities provide additional copies of data such as lab reports or radiology reports or can transmit computerized data to the professional's office directly. Remind the health care professional that the medical record can not be removed from the **premises**. Notify the appropriate administrator immediately. Hold on to the record physically if necessary. If the person is determined to take the record, do not risk physical harm, let him or her take it. Then take appropriate steps that your facility requires to report the removal. Complete an incident report as indicated or required.

Document the health care professional's statement of intent to remove the record. Record the name of the professional, date, time, statement, and your response. Document the names of witnesses and the name of the administrator notified.

If the health care professional leaves the facility or home with the record, start a second record and label it "Temporary Record". Write a note explaining the reason for creating the temporary record, and thoroughly document the events leading to the removal of the record. Attempt to reconstruct the record identifying the source of the original information. Obtain copies of lab results, prescriptions, etc. from appropriate departments.

When the medical record is returned, the person receiving the record must review the record for alterations and deletions and document such changes on the appropriate form. Notify the administrator of any changes to the record. Notify any health care professionals involved in the individual's care of the changes to the record so review of the treatment plan can be completed. Document the time the additional professionals were notified, their responses, and other measures taken to safeguard the individual.

Points to Ponder

The medical record is a legal document that belongs to the facility or agency. Health care professionals may request a copy of the record for valid purposes, they can not remove the original record.

PREVENTING MEDICAL RECORD DESTRUCTION

- ✓ The most serious form of tampering, destruction of a person's medical record is legal suicide.
- ✓ The health care provider who destroys the record – and possibly the employer stands virtually no chance of prevailing in court if a person sues for malpractice.
- ✓ The jury will assume that the record was destroyed because it contained extremely damaging information.

Taking precautions

- ✓ If one suspects that a colleague is planning to destroy all or part of a person's medical record, alert the appropriate administrator immediately.
- ✓ If needed, ask the administrator to help copy the record.
- ✓ Give the copy to the medical records department, or other record management staff, for safekeeping.

D. When a nurse criticizes a colleague's care in the medical record

Disagreements among staff do not belong in the individual's record. If a colleague writes a comment criticizing your care, notify the appropriate administrator.

Do not respond in writing to the criticism. Do not alter the record. Do not delete the note. Do not add to your original note to disprove the criticism. Complete an incident report (as required) to document concerns. Do not cast blame, simply state what your saw, heard, smelled, or felt and describe your interventions.

Speak with the colleague and try to resolve the matter privately. Speak with the appropriate administrator. The administrator may call a staff meeting to discuss the correct use of notes in the record and help improve working relationships.

Points to Ponder

COLLEGIALITY: A NURSING STANDARD

If one is concerned about the quality of a colleague's care, don't air those concerns in the medical record. Instead address them in a constructive, nonthreatening way, as directed by the American Nurses Association's Standard IV:

> Titled "Collegiality," this standard states that the nurse should contribute to the "professional development of peers, colleagues, and others." To meet the criteria for Collegiality, one must:
>
> - ✓ Give peers constructive feedback about their practice
> - ✓ Share knowledge and skills with colleagues and others
> - ✓ Contribute to an environment that promotes clinical education of nursing.

E. When a nurse asks a colleague to document their care

⇒ If you document a colleague's care that you did not witness or participate in, you can be held liable for his or her errors.

⇒ Refuse to document care that you did not witness or participate in. Tell the colleague that this practice would place both of you in a legally indefensible position. Offer to help him or her complete other care tasks so he or she has more time to document the care provided.

⇒ If a colleague calls with routine information that he or she can easily document on their next shift, suggest that the information be added as a late entry.

⇒ If the colleague calls to report information he or she forgot to document, you are legally permitted to record this information. You must be certain to label it as a telephone report from the previous nurse, note the date and time of the entry, and record your colleague's name. If required by the facility, use any special form to record telephoned information instead of recording it in the nurses' notes.

F. When a nurse suspects a colleague of negligence

The American Nurses Association Code for Nurses requires that nurses report a colleague's negligence or unsafe practice. The doctrine of qualified privilege legally protects the nurse who reports a negligent colleague. However, reporting a colleague may lead to retaliation.

If you suspect a colleague of professional negligence, first make sure you are seeing the whole picture. Gather all the facts. What appears to be negligence may be an acceptable alternative method of providing care.

Report your belief through the appropriate channels. According to facility policy, complete the necessary report or form. Keep to the facts, be objective. Do not cast blame. Provide information about the incident and those who were notified. Describe your actions to prevent further harm. Notify the health care provider that a report has been filed, even if it is the health care provider that is being reported. In the nurses' notes document the care you provided to prevent or minimize harm to the individual. Do not indicate that you have filed an incident report.

Points to Ponder

UNDERSTANDING QUALIFIED PRIVILEGE

- ✓ Normally, someone who impugns (points the finger at) a person's professional reputation or capacity can be sued for defamation. However, nurses and others with a legal obligation to report honestly on colleagues' performance are protected by *qualified* privilege.
- ✓ This doctrine gives the nurse immunity against charges of libel (written defamation) and slander (oral defamation) because of the overriding public interest–persons' well being – takes precedence over a person's professional reputation.
- ✓ Keep in mind, though, that qualified privilege applies only to statements made to protect a person they serve. It does not apply to idle gossip that reflects on a colleague's professional capabilities or motives, even if those statements are true.

G. How to handle a primary care provider's questionable order

Courts are ruling that nurses must speak out on an individual's behalf and document concerns about any questionable orders. If the health care provider insists that you administer the questionable treatment, you have a duty to refuse and to document your refusal and rationale. You have the right to refuse if the order goes beyond your scope of practice or directly violates the state's nurse practice act, the facility policy and procedure, or professional standards. Discuss your concerns with the provider and document the discussion in the record.

To support your belief that the order is questionable, record the assessment findings and other pertinent information concerning the individual. Document the discussion with the health care provider about the treatment. Document your refusal, the rationale, the names of the persons notified, and their responses and note the times. Describe the facts. If necessary, complete any forms required by the facility. Keep a copy of any forms for your files.

How to handle a primary care provider's questionable order continued:

Points to Ponder

Although you have a duty to implement an order as written, your primary duty is to protect the individual's well-being.

QUESTION, DO NOT COUNTERMAND

- ✓ Although the nurse is obligated to question a primary care provider's potentially harmful or inappropriate order, he or she has no right to countermand or alter it.
- ✓ Countermanding or altering an order is a violation of the Nurse Practice Act and exposes the nurse to charges of insubordination and practicing medicine without a license.
- ✓ If the nurse believes that the person could be harmed if the questionable order was carried out, try to delay implementation until the issue has been resolved.
- ✓ If the issue cannot be resolved by speaking directly with the primary care provider who gave the order, talk with the appropriate administrator and, if necessary, a higher-level administrator.

H. When a primary care provider's order is illegible

Clarify an illegible or incomplete order at once. The risk of error and consequent harm is too great. Ask the health care provider to rewrite the order to eliminate uncertainty about its content. Or ask the provider to review orders with you routinely before he or she leaves. If you are unable to reach the health care provider, notify the appropriate administrator.

Document attempts to contact the health care provider to clarify the order. Record the method of contact (phone or pager), and the time of each attempt.

Once the provider clarifies the order, transcribe it on the appropriate order sheet, marking your entry as a clarification of an earlier order. Then document in your nurses' notes that the order has been rewritten so other health care team members will see that the order was clarified.

If a colleague has interpreted the order for your, ask him or her to print the questionable word or words above the original writing and then sign and date his or her notation.

Points to Ponder

WHAT TO DO IF YOU CANNOT REACH THE PHYSICIAN

- ✓ If the primary care provider cannot be reached to clarify the order, notify the appropriate administrator.
- ✓ In an emergency or urgent situation, the nurse may consult the chief of staff or medical director, or other appropriate authorities. Or the nurse may ask the primary care provider's partner to clarify the order.
- ✓ If the primary care provider is busy treating other person's whose condition is more critical, document that he/she was contacted and expect him/her to respond as soon as possible. This notation protects the nurse and the primary care provider in case the person later sues.

Section IV. Protecting confidentiality through other documented mediums:

A. When someone asks to photograph or videotape the person

Using an individual's picture without consent violates their right to privacy and can result in legal action. As with consent for a medical procedure, a consent to be photographed or videotaped is only valid if the consent is informed and the individual is of legal age. Informed consent means the person is told why the photo or tape will be taken and where and how it will be used. If the photo or tape is later used for a different purpose, this violated the individual's rights.

Make sure the facility approves of the project before the individual consents to a photo or videotape. Do not let researchers or journalists approach an individual unless this person has authorization from the facility. Have someone from the public information office or the person in charge of the project explain the request to the individual and ask for the consent. Do not involve yourself in the request. Make sure the individual receives all the information needed to make an informed decision.

SMILE!

Most facilities have a special consent form for photography and videography. This form should specify how and when the photograph or videotape will be used and give the individual's full name, address, and phone number. Place one copy of the form in the individual's record, give one to the individual, and another to the photographer or videographer.

In the nurses notes, document the name of the person who spoke to the individual about the project. Summarize the content of the discussion, the outcome, and the individual's response.

If the individual withdraws consent or changes their mind, document the decision along with the date and time. Also document the names of the persons notified of the withdrawn consent.

Points to Ponder

The law protects all citizens against unreasonable and unwarranted interference with solitude. This right to privacy extends to an individual's name and picture.

DISPUTING DISGUISED IDENTITY

A person (or their legal guardian) may consent to being photographed or videotaped on the condition that their identity be disguised. But obtaining consent with this stipulation can be a difficult situation for everyone. Lawsuits have been brought against health care facilities and were lost because later it was learned they could be identified. To avoid these problems, those persons who do not want their identities know should be advised of this possibility.

B. When a member of the media asks for medical information

Review and follow the facility policy on disclosing individual's information. Refer the journalists or other requester to the department that deals with the media. Notify the appropriate administrator of the request, and tell other health care team members about the incident so they will be on guard.

"No comment"

Document the name of the person who requested the individual's information, the organization, and the specific request. Record your response and the name of the administrator notified. Record the names of staff members you informed of the incident. Document further attempts made to obtain information during your shift.

The law requires health care providers to report communicable diseases to the state health department, positive human immunodeficiency virus test results to the Centers for Disease Control and Prevention, and suspected child abuse to local officials. Also, in some cases, the public's right to know may override the individual's right to privacy. Refer the requester to the appropriate facility department.

Points to Ponder

Protecting an individual's right to privacy and confidentiality means keeping all information—even admission to the health care facility—confidential.

DISCLOSING MEDICAL INFORMATION: THE A.N.A.'S VIEW

- ✓ The *Code for Nurses* (American Nurses Association, 1985) outlines the legal and ethical responsibilities in protecting the person's confidentiality. It emphasizes that you must consider the person's rights, well-being, and safety when deciding whether to disclose confidential information about him/her. It stresses that when disclosing personal information to other health care team members, you should include only the data that is pertinent to the person's treatment and welfare.
- ✓ The *Code* addresses how to document the person information required for peer review, third party payment, and other quality management.

C. How to protect confidentiality when faxing medical records

Except in unusual circumstances, send or request information about an individual by fax only if this data is needed urgently. Because faxing speeds information transmission, it helps health care professionals make more informed decisions quicker. An insurer may require a facility to fax relevant medical information.

Before sending a fax, check the fax number twice to make sure it is going to the correct fax machine. Always use a cover sheet to include the date, time, your facility name, address, phone and fax number, your name, recipient's name, address, phone and fax number, the number of pages being faxed, and the importance of keeping the faxed material confidential. You may also need to include instructions for verifying receipt of the fax.

How to protect confidentiality when faxing medical records continued:

If the intended recipient does not receive the fax, check your fax machine's logging system to determine where the fax was sent or if a transmission error occurred. If the fax went to the wrong number, send another fax to that number explaining your mistake and request return of the material via the mail. Also, inform the appropriate administrator of the error. Then fax the information to the correct number.

Keep faxes confidential.

If a transmission error occurs, call the intended recipient, verify the fax number, and request that the fax machine be checked for malfunction. Resend the material when the machine is working. Do not assume the recipient is aware of the malfunction.

As a general rule, do not fax routine information concerning an individual to insurance companies or attorneys. Instead send the information by regular mail. Check with your facility policy for other restrictions on faxing of confidential information.

Typically the individual must give written authorization to fax their information. Exceptions may apply. For example an individual may be comatose and their legal representative can not be found, then the facility's legal counsel may permit medical information to be faxed to a requesting health care provider.

Document which information was faxed, the date, time, and your signature. Check the policy of the facility to determine which materials are required to be placed in the record. It may be necessary to place a copy of the entire fax in the record. Always include the signed authorization for the fax, the cover sheet, and the fax receipt in the record.

If the information was sent to the wrong fax number, document the error and note that the information was re-sent and the corrected fax number. Record the name of the person who will mail the misdirected fax to your facility. Make additional notations as required by facility policy.

Points to Ponder

KEEPING FAXES CONFIDENTIAL

- ✓ A facsimile (fax) machine that is used to send and receive medical information should be kept in a private area with restricted access. If possible, one person should monitor all fax transmissions.
- ✓ When a fax arrives, it should be removed immediately, count pages to make sure the entire fax is received, and review the material for legibility. If a problem is found with the fax, the sender should be called to report the problem.
- ✓ If the fax is complete and legible read the cover sheet for instructions on how to verify receipt. After verifying receipt, notify the intended recipient; place the faxed document in an envelope or folder, seal and deliver or store in a secure location until it can be delivered.

Dealing with confidentiality breach

To preserve confidentially, take steps to prevent unauthorized or inappropriate people from reading or receiving faxed information. If an unauthorized person is seen reading a confidential fax, politely ask the person to identify him or herself. If the person is not involved in the person's care, ask for the fax. Then report the incident to the appropriate authority. Document the event in an incident report.

C. How to protect confidentiality when using the Internet


Personal possessions are important.

If your facility sends medical information by e-mail, find out what precautions are in place to protect the individual's confidentiality. If you are unsure if authorization by the individual is required, consult the facility's legal counsel.

Many health care providers routinely use electronic mail (e-mail) to send and receive information, including laboratory test results, specialist referrals, hospital discharges, and prescriptions. Be aware that e-mail messages are easy to forge or intercept. This same information could be sent by mail or facsimile.

Typically, the individual's written authorization must be obtained before the medical information is e-mailed. When sending e-mail always start the message with the facility name, address, phone number, and e-mail address. Add your name, the recipient's name, address, phone number and e-mail address. Include any identification numbers of the recipient. Finally, include a statement emphasizing the need to maintain confidentiality. Depending on the facility policy, you may need to include instructions on verification of receipt of the e-mail. If the confidential e-mail goes to the wrong address, send an e-mail message to that address explaining the mistake. Request that the recipient delete the first e-mail message and notify you of its deletion by e-mail. Inform the appropriate administrator. Resend the e-mail to the correct recipient. Follow facility policy on reporting the incident.

Include a copy of the authorization to e-mail medical information in the record. If the individual expresses concerns about e-mail transmission, document them along with your response and teaching. Also place a copy of the e-mail transmission log in the individual's record. If a response to the e-mail is received, print it out and place it in the record also.

Points to Ponder

Caution!
Beware of potential loss of confidentiality as medical information travels from one computer to another!

HOW E-MAIL WORKS
An e-mail message is an electronic message sent from one computer to another. After the message is prepared and sent the message travels from the senders computer to the Internet service provider, then to another Internet service provider and, finally, to the receiving computer.

Understanding e-mail addresses
- ✓ E-mail addresses have four components: the user's name, an "at" symbol @, the domain name followed by a period, and provider abbreviation (name@domain.provider).
- ✓ Typically, the user's name is unique to the person or department, like a phone number or extension. The @ sign denotes that the user is "at" the domain. The domain is the organization to which the user belongs.

The provider abbreviation denotes the type of Internet service provider:
- "com" indicates a commercial Internet service provider.
- "edu" stands for an educational Internet service provider.
- "net" stands for a network Internet service provider.
- "gov" indicates a government Internet service provider.
- "org" refers to an organization's Internet service provider

Division of Mental Retardation

April 2002

Best Practice Guidelines

Assessment of Acute Illness and Injuries

Special points of interest:

- General Guidelines for Seizure Management
- Anticipated Outcomes
- Special Focal Points
- Points to Ponder

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Section I. Overview:

A through nursing assessment should be performed on all individuals experiencing an acute clinical episode. The chief complaint and degree of distress will determine the priorities of the assessment. Document everything the individual tells you. If necessary, obtain data from other sources such as family or caregivers.

The nurse must focus on the immediate health care problem of the individual, yet remain aware of any trends that may be developing. Every system should be assessed unless the affected system is apparent; i.e., obvious bleeding.

To provide a data base on which to build the foundation for future assessments, it is necessary to take vital signs, oxygen saturation (O_2 SAT) if applicable, and other pertinent findings.

The systematic review provides nursing information in a readily accessible and well organized manner. The focus of documentation will be on the nursing assessment date, the nursing interventions, and the individual's response.

I feel different today.

Depending on the findings from the assessment, perform and document rapid interventions needed to address urgent medical problems uncovered. Document teaching about all topics relevant to the care and condition of the individual.

Signs and symptoms of illness to be reported to nursing and medical personnel when symptoms are first recognized include:

- √ All accidents and injuries
- √ All individual's complaints of illness
- √ All physical and behavioral changes which differ from the individual's normal pattern

Anticipated Outcomes of Acute Illness and Injuries

1. All health issues will be identified when symptoms are first recognized and immediately referred to the appropriate personnel.

2. In the event of an acute illness or injury (e.g., head injury, musculoskeletal injury, laceration requiring physician notification, etc.), documentation utilizing the SOAP format should occur in a timely manner. Be sure to include any pertinent negatives—absence of a significant finding, such as "no abdominal tenderness" in an individual with abdominal distention.

Section II. Nursing process for assessment of acute illness and injury:

A. Document what the individual tells you

Document the exact time the signs and symptoms, or change in health status led the individual to seek medical care.

Record the individual's chief complaint exactly as he or she relates it. Place quotation marks around their words.

Use simple terms and avoid complex medical language.

Ask detailed questions to clarify the health history. Record as much detail as possible.

I hurt my foot. It feels bad. I think it has a fever in it.

B. Document what you assess

The nurse will assess each individual with as acute illness or injury in a timely manner. If an affected system is not apparent, a full body systems review will be performed. The LPN must notify the RN if the assessment requires professional nursing judgment or interventions are indicated.

Perform a physical examination, recording the information in as much detail as possible. Start by taking the individual's vital signs and measuring height and weight. Then move on to inspection, palpation, percussion, and auscultation. Record normal and abnormal responses. Note physical responses such as tenderness on palpation.

Document in a SOAP format. Include all nursing interventions performed. Even when the assessment is unremarkable, it is necessary to note the negative findings.

Document communication with the health care provider, direct care staff, family, and individual.

Complete necessary forms or reports as required by facility policy.

I think I might be sick?

The nursing assessment will include:

- ⇒ Subjective information
- ⇒ Full vital signs plus oxygen saturation (O_2 SAT) reading if respiratory distress is evident and equipment is available
- ⇒ Review of the appropriate body system or full body systems, if indicated
- ⇒ Nursing diagnosis or analysis of the problem
- ⇒ Recommended plan of action based on the nursing process

Those problems recognized by the professional nurse as medical problems, will be referred to the health care provider for a comprehensive evaluation and treatment plan in an appropriate time frame.

The nurse will ensure that the defined medical and nursing plan of care is promptly initiated.

The nurse will establish the frequency and extent of follow-up assessments required by nursing and direct care staff.

C. Document what you communicate

The nurse will inform the physician immediately of problems that require primary care provider evaluation and intervention.

The nurse should indicate the following when communicating signs and symptoms of illness or injury to the health care provider:

- ~ A brief summary of the individual's medical history (include chronic health issues)
- ~ The individual's vital signs
- ~ Objective information obtained during the nursing assessment
- ~ Current medications and treatment (noting any changes in the past 72 hours)
- ~ Allergies and special precautions
- ~ Document noteworthy nonverbal behavior, such as lack of eye contact.
- ~ Also record stressors in the individual's life. And describe the mechanisms he or she uses to cope with them.

The nurse will inform the direct care staff of all monitoring and/or follow-up responsibilities.

Communications with the interdisciplinary team members should note if the illness or injury impacts on the individual's support plan (ISP).

The nurse will ensure that all pertinent information is included on the shift to shift reports. The nurse will ensure that all appropriate staff are aware of the required monitoring and follow-up responsibilities.

C. Document what you teach

To provide a baseline for later teaching sessions, document your assessment of the individual's understanding of every topic you teach.

Focus on teaching pertinent subjects, which may include:

Document every opportunity for teaching.

- Disease process
- Prescribed drugs, including the drug names, dosages, administration times and routes, special precautions, adverse effects, and storage
- Scheduled tests and procedures
- Safety measures, including the need to call for assistance
- Ambulation privileges or restrictions
- Nutritional needs, supplements, or restrictions
- Signs and symptoms to report
- Community resources
- Home care

Points to Ponder

Perform a physical examination. Follow a systematic approach. Record normal and abnormal findings. Document in as much detail as possible.

Vital signs, height , and weight.
Obtain and record the heart rate, respiratory rate, temperature, and blood pressure. Measure height and weight, noting the type of scale used, time of day, and the clothing being worn. Record any recent weight gain or loss reported. Do not rely on a guess as to the actual weight of a person.

Head and neck.
Check for and document asymmetry, unusual hair distribution, and other abnormal findings. Look for lesions, lumps, edema and erythema. Look for jugular vein distention.

Palpate the carotid pulses one at a time, document rate, intensity, and any abnormal findings.

Note the location, size, and mobility of palpable lymph nodes. Record the results of cranial nerve testing.

Eyes, ears, nose, and throat.
Evaluate and document the visual acuity. Note if eyeglasses or other vision correction devices are used. Assess and document eye movements, tearing, color recognition, scleral characteristics, and pupil reaction to light.

Evaluate hearing and document the results. Note if a hearing aid is used. Include observations of the external ear, auricle, and tympanic membrane.

Note nasal flaring or obstruction. Document the color and consistency of secretions, and abnormalities.

Document dental or gum abnormalities. Note if dentures are used. Record observations of the mouth and throat and swallowing ability.

Assess and document movement of the facial muscles and joints. Assess integrity of the gag reflex.

Do you really need to look at that?

Nervous system.
Evaluate and document the coordination, motor and sensory functions, reflexes, nerve functions, level of consciousness, memory, cognitive ability, judgment, speech, and mental and emotional status.

Document complaints of headache, blurred vision, vertigo, and light-headedness. Evaluate and document the individual's orientation to person, place, time, and situation. Determine knowledge of current events. Record specific examples if there is confusion or memory loss.

Document assessment of the individual's speech and thought processes and ability to understand what he or she is told. Note communication needs and needs to perform activities of daily living. Describe the attention span. Note signs of anxiety, agitation, and irritability.

Respiratory system.
Evaluate and document the individual's respiratory rate and rhythm, use of accessory breathing muscles, chest expansion, and skin and nail bed color. Record chest auscultation findings and document tracheal position.

Percuss the chest and assess for fremitus (a palpable vibration, as felt by the hand placed on the chest during coughing or speaking). Evaluate for dyspnea and chest pain, and note cough and sputum production.

More Points to Ponder

Cardiovascular system.
Document the individual's pulse rate, rhythm, and intensity.

Record orthostatic blood pressure changes.

Auscultate and document heart sounds, and record reports of chest pain and shortness of breath.

Evaluate the arms and legs for edema, capillary refill, temperature, and color. Record the findings. If electrocardiography is performed, document the rhythm, rate, and any abnormalities of the heart that it shows.

Gastrointestinal system.
Inspect the abdomen and document if it is flat, round, distended, concave, or symmetrical.

Auscultate for bowel sounds. Percuss the abdomen and liver. Describe the location of the liver border and note any ascites. Record the findings.

Document areas of abdominal tenderness or guarding. Palpate the spleen and kidneys and record the findings.

If detected abnormalities, describe the location, such as the right upper abdominal quadrant.

Elimination.
Note the color, clarity, amount, and odor of the individual's urine.

Record the color and consistency of the stool, and check it for blood.

Document the assessment of the perianal area for skin abnormalities, hemorrhoids, and loss of sphincter tone.

Physical assessment involves all body systems.

Reproductive system.
Document abnormalities seen when inspecting the genitalia. Note scars and moles in this area and abnormal vaginal or penile drainage.

For females, inspect and palpate the breasts and document the findings.

Musculoskeletal system.
Assess and document the range of motion, gait, posture, symmetry, body alignment, muscle strength, and joint movement.

Note deformities and edema around joints. Record reported pain and if the pain worsens with any movement.

Describe the use of assistive devices (cane, walker, wheelchair, prostheses, orthotic device).

Skin.
Assess and document the color, tone, texture, moistness, hygiene, and turgor. Look at moles and stoma sites.

Note the hair distribution and inspect for lesions. Evaluate the condition of the nails and hair.

Document areas with obvious skin breakdown. Pay special attention to reported problems such as rashes and itching.

Psychosocial status.
Document noteworthy nonverbal behavior, such as lack of eye contact. Record stressors in the individual's life, and describe the coping mechanism used.

Division of Mental Retardation

April 2002

Best Practice Guidelines

Follow-up of Acute Illness and Injuries

Special points of interest:

- General Guidelines for Seizure Management
- Anticipated Outcomes
- Special Focal Points

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Section I. Overview:

Individuals with an acute illness or injury require close observation to facilitate timely and appropriate interventions. The nurse will fully utilize the nursing process when monitoring an acute illness or injury.

Baseline data obtained during the initial assessment should be used. This data forms the foundation upon which to measure clinical progress or clinical deterioration. The nurse will perform the routine assessments as dictated by the affected body system or systems.

All illnesses or injuries should be monitored from diagnosis until resolution. The nurse will create a nursing plan and make alterations, when needed. The nurse will implement the plan. During the entire cycle of treatment the nurse will make frequent evaluations of the individual's clinical condition and the current plan to ensure appropriateness and effectiveness.

Communication of the individual's needs and requirements for follow-up should be made known to appropriate team members. These team members may include the primary health care provider, related health care services, direct care staff, families, and other members of the interdisciplinary team.

Anticipated Outcomes of Acute Illness and Injuries

1. After the initial assessment of each episode of acute illness or injury, the individual will be closely monitored for a designated appropriate time period until resolution. This time period will be determined by the illness or injury and the body system affected.

2. Documentation will occur throughout the course of acute illness or injury to include all nursing interventions and the individual's response until full resolution has occurred. Thorough documentation helps you evaluate the plan and revise it as needed.

3. The nurse will ensure that all members of the interdisciplinary team are aware of specific issues relating to the illness or injury. This is necessary as the involvement of other team members may be needed in follow-up and monitoring.

Section II. Nursing intervention and observation of acute illness or injury:

A. Individual sustaining a Head Injury with Potentially Serious Sequelae

After an initial assessment by a Registered Nurse, there will be a follow-up evaluation by a nurse at least once per shift for the first 24 hours.

Follow-up evaluation by a nurse will be required at least daily for the next 48 hours or as directed by the primary health care provider.

Document, record, and communicate all evaluations; provide complete details. Report immediately any signs of decline from baseline.

Nursing interventions and observations are required.

B. Individual with a Temperature of 101° Orally or Greater

I have a fever.

There will be a follow-up nursing evaluation on each shift for individuals with a temperature equivalent to 101 degrees orally or greater until the individual is afebrile for 48 hours.

Fever may be the earliest indicator of a serious problem. Document, record, and report any abnormal symptoms associated with the fever. Look for signs of decreased urine output, increased respiratory rate, increased pulse rate, and dehydration. Observe for shivering and diaphoresis. Encourage limitation of the individual's physical activity. Assess the environmental temperature.

C. Individual on Antibiotic Therapy

There will be an evaluation by a nurse at least daily during the first 72 hour period when an individual is receiving antibiotic drug therapy for an **acute** illness.

The evaluation will address the efficacy of the treatment and any side effects which the individual may encounter.

An individual may report a symptom that involves a single body system, such as a rash. He or she may report symptoms that involve multiple body systems, such as nausea, wheezing, and dizziness. Document, record, and report all symptoms to the health care provider. Consult the physician before discontinuing a drug.

Document effects of antibiotics. Complete the prescribed dose.

D. Individual requiring Suturing

There will be an evaluation by a nurse at least daily while sutures are in place to inspect the incision site for signs of infection.

Sutures are foreign bodies and thus capable of causing local inflammation. Record, document, and report signs of infection to the primary care provider immediately. Provide complete details as to amount, color, and odor of drainage from the suture site.

Remove the bandage to view the site.

Follow physician orders when caring for the site.

Nursing intervention and observation of acute illness or injury continued:

E. Individual with a Cast in Place

Assess capillary refill.

After the cast is applied and dry, there will be an inspection of the cast site and an assessment of the affected site at least every shift for **three** days, and then daily until the cast is removed.

Leave the casted area uncovered. Monitor the mobility of the fingers or toes. Assess the circulation and sensation in exposed fingers or toes at frequent intervals. Report significant abnormal findings promptly, especially those that progressively worsen.

Caution individual not to insert objects like straws, combs, eating utensils, and the like within the cast. Notify the primary care provider if odor or irritation is present. Immediately report swelling of tissue or signs of bleeding.

F. Individual with Vomiting or Diarrhea Episodes

There will be a follow-up evaluation by a nurse at least every shift when an individual experiences vomiting and/or diarrhea, until he or she is symptom free for 24 hours without vomiting and/or diarrhea.

Diarrhea is the urgent passage of watery stools accompanied by abdominal cramping. Simple diarrhea tends to have a sudden onset and last only a short period of time. If the diarrhea is not relieved within 24 hours, it may be best to consult a physician.

Vomiting results when the contents of the stomach are expelled through the mouth. Projectile vomiting is that which occurs with great force. Projectile vomiting is associated with certain disease conditions, such as increased pressure in the brain. Monitor for signs of aspiration.

With both vomiting and diarrhea it is important to monitor the individual for signs of dehydration. Document, record, and report episodes of vomiting and/or diarrhea. Provide complete details. Note amount, frequency, color, odor, and appearance. If the characteristics are unusual, a specimen should be saved in case the physician may want to examine it.

G. Individual experiencing a Major Choking Episode

There will be a follow-up evaluation by a nurse when an individual experiences a choking episode; the assessment will occur at least daily for 72 hours. The primary care physician will be notified of all choking episodes.

Monitor the individual for signs of airway obstruction, fever and aspiration. Record, document, and report all choking episodes. Provide complete details.

If choking occurs while a person is eating, airway obstruction is a probability. If airway obstruction exists, and is unrelieved, the victim will collapse, become unconscious, and eventually die. The victim of airway obstruction may be observed to:

- Grasp his or her throat with the hands
- Make aggressive efforts to cough and breathe
- Produce a high-pitched sound while inhaling
- Turn pale and then blue
- Be unable to speak, breathe, or cough

Report every choking episode.

Nursing intervention and observation of acute illness or injury continued:

H. Individual experiencing a Human Bite that breaks the skin

There will be a follow-up evaluation by a nurse at least daily for 48 hours, or until the potential for systemic disease is eliminated.


Don't bite me.

The individual's current tetanus status will be documented. The infection control administrator will be notified as identified in facility policy.

Human Bites are usually of two types:

1. Occlusional injuries - mostly to fingers but can be on arms, breasts, or genital areas.
2. Clinched-fist injuries usually involve metacarpophalangeal joint of the dominant hand. May be associated with fractures.

Hand wounds are usually more serious than wounds elsewhere. Common Pathogens usually found in human bites may include:

- √ S. aureus
- √ Eikenalla corrodens
- √ Various anaerobic species - most frequently Bacteroides sp.
- √ Alpha hemolytic streptococci - E. corrodens and alpha hemolytic strep act synergistically in causing indolent and serious infections

Document, record and report in complete detail the evaluation of the wound. Monitor and immediately report symptoms of systemic disease to include; fever, fatigue, malaise, lymph node enlargement, loss of appetite, nausea, and vomiting.

I. Individual experiencing Signs and Symptoms of Respiratory Distress

The nurse will perform a thorough evaluation of the individual's respiratory system including:

- » Addressing any airway problems
- » Assessing breathing by listening with a stethoscope for breath sounds
- » Assessing the individual's skin and nail bed color
- » Measuring an oxygen saturation level with a pulse oximeter (if available; compare with baseline saturation rate if available)
- » Recognizing a "panic level" for oxygen saturation as less than 90%
- » Calling the physician immediately when oxygen saturation level is less than 90% (orders may differ for chronic COPD individuals)
- » Administering oxygen by mask when oxygen saturation is less than 90% (follow facility policy)
- » Calling the respiratory therapist (if available)
- » Appropriately transferring the individual to the hospital or infirmary (follow facility policy)


Lack of oxygen can lead to brain damage or death.

Vital sign measurement of respiratory rate, pattern, and depth, along with oxygen saturation level, allows the nurse to assess ventilation, diffusion, and perfusion. Record, document, and report all incidents of respiratory distress. Provide complete details.

Nursing intervention and observation of acute illness or injury continued:

J. Additional interventions

All other illnesses and or injuries not included in the aforementioned lists will be dictated by the Registered Nurse as to a frequency and extent of follow-up. Any changes in an individual's condition warrants timely documentation to keep a record accurate. Follow facility policy concerning completion of required forms.

Follow-up on acute illness or injury.

Section III. Communication and documentation:

A. Communicate with other team members

The primary care provider will be notified of all significant changes in the individual's clinical condition or when medical interventions are not effective.

The nurse will request that staff concerns and observations regarding the individual's health status be reported to the appropriate nurse, administrator, or primary care provider.

If the individual's condition requires a change in habilitative programming, an interdisciplinary team meeting should be requested.

Follow facility policy concerning communication and the required forms.

Communication is the key!

B. Documentation

Documentation is required.

Always document that you reported pertinent information to the physician and other health care team members, along with the time of notification and the person's name and response.

All follow-up nursing assessments will include a review of the affected body system and vital signs, when indicated.

All follow-up nursing assessments will be written in S.O.A.P. format.

All follow-up nursing assessments will include all nursing interventions and the individual's response.

All follow-up nursing assessments will include communication with the primary care provider, direct care staff and family members.

Division of Mental Retardation

April 2002

Best Practice Guidelines

Seizure Management

Special points of interest:

- General Guidelines for Seizure Management
- Anticipated Outcomes
- Special Focal Points
- Points to Ponder

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Section I. Overview:

Typically a seizure is self-limited and poses no immediate threat to an individual's life. Seizure management involves all health care team members. During a seizure an individual may fall or aspirate gastric contents into the lungs. All staff should be educated on the management and protection of the individual during and after a seizure. Status epilepticus (a series of uninterrupted seizures) may cause permanent brain damage or even death unless halted promptly. Assessment and descriptions of the seizure and a reporting mechanism are important factors in seizure management and the responsibility of the person who witnessed the event.

Document any seizure.

All seizures should be reported. Seizures of three minutes or greater require a documented assessment. Unusual, new onset or clustering of seizures require assessment, documentation, and physician notification.

Instruct staff not to perform CPR during a seizure. Inform staff not to restrain the individual during the seizure. Explain to the staff the importance of having the individual receive their prescribed medications on time and as ordered.

Anticipated Outcomes of Seizure Management

1. A decrease in the signs or symptoms of seizures will occur. When signs or symptoms occur, they will be promptly recognized as an actual problem and appropriately treated.

2. Individuals will be protected from physical harm or secondary complications. The individual may receive care before the seizure ends, such as drugs to halt the seizure and position changes to prevent injury.

3. The person observing the individual having a seizure will document the episode and notify appropriate personnel. A detailed record of the individual's condition before, during, and after the seizure can help determine the seizure type and, possibly, its cause.

4. All staff will understand and practice methods to prevent seizures and secondary complications, as outlined in the Individual Support Plan (ISP) and the nursing plan of care.

Section II. Health care management before a seizure:

A. Document what the individual tells you

Some individuals have the ability to clearly communicate the events leading up to a seizure. Ask the individual if he or she is experiencing anything prior to a seizure. Document the response. This will help determine is he or she is experiencing other neurological problems. Record a history of diseases and conditions that tend to increase the risk of seizures. Some risks may include:

- ⇒ hypoglycemia
- ⇒ head trauma
- ⇒ alcohol or drug use

Talk with the individual. Explore factors associated with their seizures.

When the individual has a history of seizures, document the date of the initial diagnosis and the current treatment plan. Include a complete list of the current prescribed medications. Document the names, dosages, and administration times of anticonvulsants being taken. The time of the last dose of the anticonvulsant is very important.

Explore factors associated with previous seizures. Look for trends such as lack of sleep, physical exertion, and emotional distress. For individuals with diabetes look for abnormal blood sugar levels. In individuals with a history of constipation it may be appropriate to check for impaction. Document these findings in the record.

Document nonspecific symptoms the individual reports just before the seizure. These may include reports of a headache, mood change, muscle spasms, or feelings of drowsiness. It is important to note the timing of the symptoms in relation to the seizure. If the person states the presence of an aura before a seizure, document the description of the aura in his or her exact words. An aura may include:

- √ an unusual smell or odor
- √ an unusual taste
- √ nausea
- √ indigestion
- √ visual disturbances such as flashing lights, or colors
- √ a rising or sinking feeling

B. Document seizure precautions taken

When an individual has a history of seizures, there may be precautions recommended to prevent injury. Follow the health care provider recommendations as allowed by facility policy.

Some suggestions may include:

- ➲ Keep the bed in a low position
- ➲ Remove unnecessary objects from environment
- ➲ Pad sharp corners, as required
- ➲ Raise and pad the side rails, if used
- ➲ Keep call button within easy reach, if used
- ➲ Keep suction equipment available, if ordered
- ➲ Keep resuscitation equipment available, if required
- ➲ Keep emergency drugs nearby, if ordered
- ➲ Know location of hand-held magnet as part of vagus nerve stimulation, if used

Document any instructions to the individual to report an aura immediately.

C. Document what you assess

The person witnessing the seizure will complete information needed to accurately document the seizure. Follow facility policy and procedure for the instruction and completion of any forms. Keep records of all seizures.

⇒ Begin documentation by describing events that preceded the seizure; i.e., any aura, any outcry, any other behavior.

⇒ Record the date, time seizure began, time seizure ended.

⇒ Document the sequence of movements and body parts affected, if present; level of consciousness; the presence of cyanosis or respiratory distress; bowel or urinary incontinence.

⇒ Document precipitating factors, if known.

D. Document what you do

Record the interventions that are taken to maintain safety before, during, and after the seizure.

Record any interventions used to halt the seizure or position changes to prevent injury.

Document the name, dosage, time and route of any anticonvulsant given. Note the drugs effectiveness in resolving the seizure.

Review, monitor, create, instruct, and communicate.

Points to Ponder

Nursing Process :

The nurse will review documentation of each seizure and obtain information from the person witnessing the seizure to identify the type, frequency, and pattern of the seizure.

The nurse will check lab results for anticonvulsant medication levels. If there is a significant change in frequency or pattern, notify the physician.

The nurse will create a plan with instructions regarding the frequency of a nursing follow-up evaluation if necessary. The nurse will make recommendations for monitoring by direct care staff.

The nurse will inform the appropriate administrator of specific issues relating to the individual's seizures that may require the involvement of the direct care staff.

The nurse shall participate as appropriate in health education for the direct care staff concerning individual specific seizures. This may be accomplished formally in the annual staffing, or informally through role modeling and during the day to day contact.

The nurse will communicate with the appropriate contact (QMRP or ISC) if seizure management is affecting the current support plan (ISP).

The nurse will request that all staff concerns regarding the individual's seizures be communicated to the appropriate nurse and primary health care provider.

Section III. Health care management during a seizure:

A. Interventions during the seizure

Record every action that is taken to safeguard the individual during the seizure. Generalized tonic-clonic seizures may require first aid for bruises, abrasions, and mouth or tooth injury. Other types of seizures may require minimal interventions. Document the appropriate interventions.

Several appropriate interventions may include:

- √ Position individual **on** their **side** (to prevent aspiration)
- √ Loosen clothing, postural support devices, restrictive restraints
- √ Remove harmful objects from individual or environment to prevent and protect from bodily injury
- √ Do not physically restrain or place anything in the individual's mouth
- √ Monitor breathing and check for cyanosis
- √ Stay at the individual's side until the seizure ends
- √ Call for assistance
- √ If seizure lasts longer than 3 minutes, follow facility policy for notification of physician, nurse, or other appropriate administrator.
- √ Note precipitating factors (room temperature, activity, noise level, etc.)

The nurse will arrive to evaluate the individual within five minutes (or as facility policy requires) of being called to assess the individual and check the following: neurological status, signs of injury, and perform a fecal impaction check if applicable.

B. Document what you do

Notify the physician immediately to ensure timely and appropriate medical treatment. Document the information you communicate to the physician, along with the time of notification, orders given, your actions, and the individual's response to the interventions. Report the individual's response to the physician, and document that information.

Notify according to facility policy.

If the physician prescribes an anticonvulsant or other drug, document each drug given along with its dosage, administration time, and route. If you administer a drug that can affect blood pressure, record the individual's blood pressure before and after he or she receives the drug. Closely observe and record the individual's response to each drug given.

The nurse will ensure that all pertinent information is included on the shift to shift report. Document your teaching and instructions to other staff.

The nurse will notify the available health care provider when the following conditions exist:

- If the individual develops prolonged cyanosis or signs of respiratory difficulty.
- If the individual does not regain consciousness between seizures.
- If the individual is still having seizures after 10 minutes (or as policy requires) from onset; the nurse will call a primary care provider to discuss management.
- If there are repeated tonic-clonic seizures (three or more, or as directed by physician).
- If there are any significant changes in frequency or patterns of seizures for an individual.

Section IV. Health care management after a seizure:

A. Interventions after the seizure

The nurse will record vital signs **post-ictally** and notify the available physician if medical intervention is warranted. Examine the individual for injuries and overall condition. Monitor the individual closely. Record the level of consciousness, and neurological status every 15 minutes or as facility policy requires. Reorient and reassure the individual and document these interventions. Document your findings thoroughly.

When describing the post-ictal period, include if the individual was:

- ⇒ drowsy, fatigued
- ⇒ confused
- ⇒ unsteady gait
- ⇒ combative or other behaviors
- ⇒ complaining of a headache

Continue to observe individual until he or she returns to baseline status.

B. Document what you do

Document all nursing interventions completed. Include vital signs and pupil response when indicated.

Document the individual's response and the nursing plan of action.

Document all drugs administered as ordered by the physician.

Document communication that occurs with the health care provider and direct care staff.

Document instructions to the direct care staff.

C. Document what you teach

When documenting your teaching, indicate any instructions to the individual , caregivers, and family about preventing and managing seizures and dealing with the precipitating condition.

Instruct all members of the health care team not to perform CPR during the seizure. Inform all members not to restrain or place anything in the individual's mouth.

Explain the importance of taking drugs exactly as prescribed.

Stress the importance of informing health care team members, family members, and coworkers if an aura occurs and the need to immediately seek safety.

Give information on how to obtain medical alert identification.

Avoid significant changes in daily schedule.

Advise individual, staff, and family of side effects of anticonvulsant drugs such as: sedation or drowsiness, lack of coordination, blurring or double-vision, and/or gastrointestinal upset.

Stress need for regular monitoring of blood levels of anticonvulsants.

Review measures to help prevent seizures such as:

- ⇒ getting adequate rest
- ⇒ avoiding triggers: video games, flashing lights, loud noises, hyperventilation
- ⇒ avoid excessive food or caffeine intake
- ⇒ avoid over excitement or overexertion
- ⇒ prevent fever, infection
- ⇒ avoid heat, dehydration
- ⇒ eat regular meals
- ⇒ note changes in bowel habits to avoid constipation
- ⇒ note time for menstruation
- ⇒ avoid food and drug interactions

Division of Mental Retardation

April 2002

Best Practice Guidelines

Maintaining Skin Integrity

Special points of interest:

- General Guidelines for Maintaining Skin Integrity
- Anticipated Outcomes
- Special Focal Points
- Points to Ponder

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Section I. Overview:

The skin is a window for the nurse to detect a variety of conditions affecting an individual. Changes in oxygenation, circulation, nutrition, local tissue damage, and hydration are just a few.

The functions of the skin are many. Skin protects against injuries and parasitic invasion. Skin aids in elimination. Skin is a reservoir for food and water, and acts as a sense organ for the cutaneous senses.

The skin responds in a relatively limited number of ways to irritation, injury, or infection.

Injury, infection, inflammation, and underlying systemic disease may affect the skin's normal color (redness, cyanosis); moisture content (clammy, dry); turgor (hydration); and texture (soft, hard, indurated).

The nurse will ensure the individual has regular physical activity, including prescribed positioning as defined in his or her physical nutritional management plan.

The nurse will observe the individual for evidence of skin breakdown, rashes, bruises, redness, or petechiae.

The nurse will be knowledgeable of stressors that increase the possibility of skin breakdown.

The nurse will ensure implementation of all health care provider and nursing orders to maintain skin integrity, including methods for preventing friction and shear.

Anticipated Outcomes of Maintaining Skin Integrity

1. Maintenance of skin integrity with no signs or symptoms of skin breakdown, or if impairment is present, the condition will be identified and prioritized as an actual problem and appropriately treated.

2. Staff will be knowledgeable and practice preventive methods to maintain skin integrity.

3. A nursing care plan will be formulated for individuals with demonstrated potential or actual alteration in skin integrity.

Section II. Nursing examination of the skin:

A. Skin pigmentation

Skin color varies from body part to body part and from person to person. Despite individual variations, skin color is usually uniform over the body,

Assessment of color first involves areas of the skin not exposed to the sun, such as the palms. The nurse notes if the skin is unusually pale or dark. Normal skin pigmentation ranges from ivory or light pink to ruddy pink in white skin; light to deep brown or olive in dark skin.

I have skin everywhere.

The nurse focuses inspection on sites where abnormalities are more easily identified. For example, **pallor** is more easily seen in the face, buccal mucosa, conjunctivae, and nail beds. **Cyanosis** is best observed in the lips, skin, and nail beds. Normal reactive **hyperemia**, or redness, is most often seen in regions exposed to pressure such as the sacrum, heels, and greater trochanter.

The nurse inspects for any patches or areas of skin color variation. With sun exposure, some areas are more pigmented. Localized skin changes, such as pallor or **erythema**, may indicate circulatory changes. Areas of redness with scaling, flaking, and cracking may indicate dry skin. It is important to ask if a change in skin color has been noticed.

Points to Ponder

Everyone should be conducting a monthly examination of the skin, noting moles, blemishes, and birthmarks. Inspect all skin surfaces. Use mirrors to assist with self-examination. Caregivers who would normally assist an individual in dressing or bathing may be helpful with this examination.

Cancerous melanomas start as small, mole-like growths that increase in size, change color, become ulcerated, and bleed. A simple **ABCD** rule (American Cancer Society, 1993) outlines warning signals:

- √ **A** is for **asymmetry**
- √ **B** is for **border** irregularity, edges are ragged, notched, or blurred
- √ **C** is for **color**; pigmentation is not uniform
- √ **D** is for **diameter**, greater than 6 millimeters

Older adults and individuals with certain chronic diseases tend to have delayed wound healing. Instruct the individual or caregiver to report any lesion that bleeds or fails to heal to a physician.

To treat "winter itch" or excessively dry skin, avoid hot water, use a superfatted soap (Dove), pat rather than rub the skin dry after bathing, apply mineral oil (if allowed) to body parts, and wear cotton clothing.

Tell individual or caregiver to report to a physician changes in skin lesions or a sore that does not heal.

Nursing examination of the skin continued:

B. Skin moisture

I'm too moist for comfort.

Moisture refers to wetness and oiliness. The nurse uses ungloved fingertips to palpate skin surfaces to feel the skin's moisture. The skin is normally dry. Skinfolds such as the axillae are normally moist.

The hydration of skin and mucous membranes helps to reveal body fluid imbalances, changes in the skin's environment, and regulation of body temperature. After exercise or exposure to warm temperatures, the skin may be moist from perspiration.

Flaking and scaling are believed to be valid indicators for abnormally dry skin. Flaking is the appearance of dandruff-like flakes when the skin surface is lightly rubbed. Scaling are fish-like scales that are easily rubbed off the skin's surface.

If there are skin lesions oozing fluid, the nurse must apply gloves and assess the color, odor, amount, and consistency.

C. Temperature of the skin

The temperature of the skin depends on the amount of blood circulating through the dermis. It is good to remember that if an examination area is cold, the individual's skin temperature and color may be affected.

The temperature is more accurately assessed by palpating the skin with the dorsum or back of the hand. The nurse compares symmetric body parts. Normally the skin is warm. Skin temperature may be the same throughout the body or may vary in one area. Skin temperature is a basic assessment when the individual is at risk of having impaired circulation, such as after a cast application.

The nurse can identify a stage I pressure ulcer early when noting warmth and erythema. If an area of redness is noted, the nurse places a fingertip over the area, applies gentle pressure, and then releases. Areas of skin affected by normal reactive hyperemia will blanch with fingertip pressure, and the condition lasts less than one hour. Normal reactive hyperemia is the redness of local vasodilation, the body's normal response to lack of blood flow. Abnormal reactive hyperemia is an excessive vasodilation and induration. It can last more than one hour and up to two weeks.

D. Texture of the skin

The character of the skin's surface and the feel of deeper portions are its texture. The nurse determines if the individual's skin is smooth or rough, thin or thick, tight or supple by stroking it lightly with the fingertips.

The texture of the skin is normally smooth, soft, and flexible. However, the texture is usually not uniform. The palms of the hands and the soles of the feet tend to be thicker. In older adults the skin becomes wrinkled and leathery because of a decrease in collagen, subcutaneous fat, and sweat glands.

Localized changes may result from trauma, surgical wounds, or lesions. The nurse asks whether there has been a recent injury to the skin. Deeper palpation may reveal irregularities such as tenderness or areas of induration, localized edema under the skin.

Texture is the character of the surface of the skin.

Nursing examination of the skin continued:

E. Skin turgor

Turgor is the skin's elasticity. Turgor can be diminished by edema or dehydration. Normally the skin loses elasticity with age.


Turgor is the skin's elasticity.

To assess skin turgor, a fold of skin on the back of the hand or forearm is grasped with the fingertips and released. Normally the skin lifts easily and snaps back immediately to its resting position. The skin stays pinched when turgor is poor.

The individual with poor turgor does not have a resilience to the normal wear and tear on the skin. A decrease in turgor predisposes the individual to skin breakdown.

F. Vascularity of the skin

The circulation of the skin affects color in localized areas and the appearance of superficial blood vessels. With aging, capillaries become fragile.

Localized pressure areas appear reddened, pink, or pale. Petechiae are tiny, pinpoint-sized, red or purple spots on the skin caused by small hemorrhages in the skin layers. Petechiae may indicate serious blood-clotting disorders, drug reactions, or liver disease.

G. Edema of the skin

Areas of the skin become swollen or edematous from fluid buildup in the tissues. The nurse inspects edematous areas for location, color, and shape. The formation of edema separates the skin's surface from the pigmented and vascular layers, masking skin color. Edematous skin also appears stretched and shiny.

The nurse palpates areas of edema to determine mobility, consistency, and tenderness. When pressure from the nurse's finger leaves an indentation in the edematous area, it is called **pitting edema**.

To assess pitting edema, the nurse presses the edematous area firmly with the thumb for five seconds and releases. The depth of pitting, recorded in millimeters determines the degree of edema. For example, 1+ edema equals 2 mm depth (2+ = 4 mm, 3+ = 6 mm, 4+ = 8 mm).

H. Lesions of the skin


Lesions can be many shapes or sizes.

The skin is normally free of lesions, except common freckles or age-related changes such as skin tags or senile keratosis. When a lesion is detected, it is inspected for color, location, size, type, grouping, and distribution. Palpation determines the lesion's mobility, contour, and consistency. It is palpated gently, covering its entire area. The nurse notes if the individual complains of tenderness during palpation.

Any abnormalities, especially lesions that have changed in character are reported to the physician because further examination may be needed. Precancerous lesions frequently undergo changes in color and size.

Section III. Nursing health education regarding the skin:


Saturday night again?

Assessment data are used to make nursing diagnoses, select appropriate nursing interventions, and measure outcomes of nursing care. When assessing older adults the nurse learns to recognize how the normal process of aging affects physical findings. Teaching should be integrated throughout the examination to help individual's learn about health promotion and disease prevention.

The nurse will educate the staff on a daily basis through role modeling and formal or informal education of the plan of care. The nurse will review the presence of risk factors for interruption or destruction of skin integrity. The nurse will instruct the staff on the importance of skin cleanliness. The nurse will inform the staff regarding the importance of maintaining dry skin. The nurse will instruct staff on the importance of proper application and proper fitting of protective and supportive devices.

Certain diseases or conditions require the need for a temporary or permanent artificial opening called a **stoma** in the abdominal wall. Skin care is important for the individual with any type ostomy. The appearance of the stoma and surrounding skin must be inspected routinely. The stoma should be moist, shiny, and dark pink to red. Report bleeding, abnormal color, or edema to the health care provider. Specific training is required to help prevent stoma site irritation. Ostomy pouches or skin barriers may be required to maintain skin integrity. Check with the health care provider or enterostomal therapist (ET) who can assist with the selection of the correct system. The enterostomal therapist can provide individual specific instruction and training to nurses and caregivers.

Section IV. Communication and documentation:

A. Communicate with other team members

The nurse will communicate alterations in skin integrity to the primary health care provider. Normally skin is intact and has no abrasions. Skin feels warm when palpated. Localized changes in texture can be palpated across skin's surface. There is good turgor, with skin generally smooth and soft. Stoma sites should be moist, shiny, and dark pink to red. Skin color varies from body part to body part.

The nurse will inform the direct care staff of specific skin maintenance issues that would require their specific involvement. Age influences the normal condition of the skin and the type of hygiene required. The condition of an adult's skin depends on hygiene practices and exposure to environmental irritants. The degree of assistance needed by an individual during bathing may depend on the individual's cognitive function, their vision, the ability to sit without support, hand grasp, and range of motion. Any break in skin integrity may lead to infection or a pressure ulcer.

The nurse will request that all staff concerns or observations regarding the individual's skin be communicated to the appropriate nurse or administrator. While assisting an individual with personal hygiene, the caregiver will assess all external body surfaces. Caregivers must be particularly alert when assessing an individual with reduced sensation, vascular insufficiency, and immobility. Dependent body parts are exposed to pressure from underlying surfaces; such as, mattresses or wrinkled linens. Individuals need to be turned frequently to ensure proper circulation and comfort.

If the individual's skin condition requires a change in habilitative programming, an interdisciplinary team meeting will be requested. The development of pressure sores is a common complication. Skin breakdown can result from immobilization. Casts, bandages, and restraints can exert pressure on underlying surfaces, causing irritation and skin breakdown.

The nurse will ensure that all pertinent information is included in the shift-to-shift reports. The nurse will instruct staff to immediately report signs and symptoms of skin breakdown; such as, redness; irritation; improper fitting prosthesis, postural, protective, and/or supportive devices. Follow facility policy regarding required forms.

Nursing communication and documentation continued:

Points to Ponder

A nursing diagnosis is accurate only if the appropriate related factors are identified. Whether an individual has an actual alteration in skin integrity or is at high risk determines the focus of the nursing intervention.

- √ Older individuals produce less sebum and perspire less and thus generally need to bathe less frequently, however, personal preference must always be considered.
- √ Older individual's skin is often more fragile; avoid hot water and use only a mild cleansing agent. Some authorities suggest the use of bath oils, use with caution because this increases the danger of falling in a slippery tub.
- √ The majority of older individuals have some degree of itching and skin sensitivity; ask the health care provider for suggestions that can offer relief.
- √ Dryness and redness is a common problem as skin ages, which worsens in cold, dry air; humidity should be kept above 40%.
- √ Unexplained bruises and skin trauma should not be ignored.

B. Documentation

1. The nurse will document the individual's response to all nursing interventions.
2. The nurse will document the local skin reaction to supportive or protective devices that may alter skin integrity.
3. The nurse will document communication with the primary health care provider regarding skin integrity.
4. The nurse will document communication with the direct care staff of any health teaching or requested follow-up.
5. The nurse will formulate a Nursing Care Plan for those individuals with demonstrated high risk or actual alteration in skin integrity.
6. The nursing summary (monthly, quarterly, or as required by facility policy) will address the skin integrity of individuals with demonstrated potential or actual problems. All nursing interventions and individual responses will be addressed.
7. A notation will be made on the required notes (monthly, quarterly, or as required by facility policy) whether the present plan of care is to be continued or if any adjustments have been made.
8. The nurse will document alteration in skin integrity and/or breakdown according to severity (e.g., Stage I, Stage II, etc.).

Nursing communication and documentation continued:

Points to Ponder

Stages of Pressure Ulcers

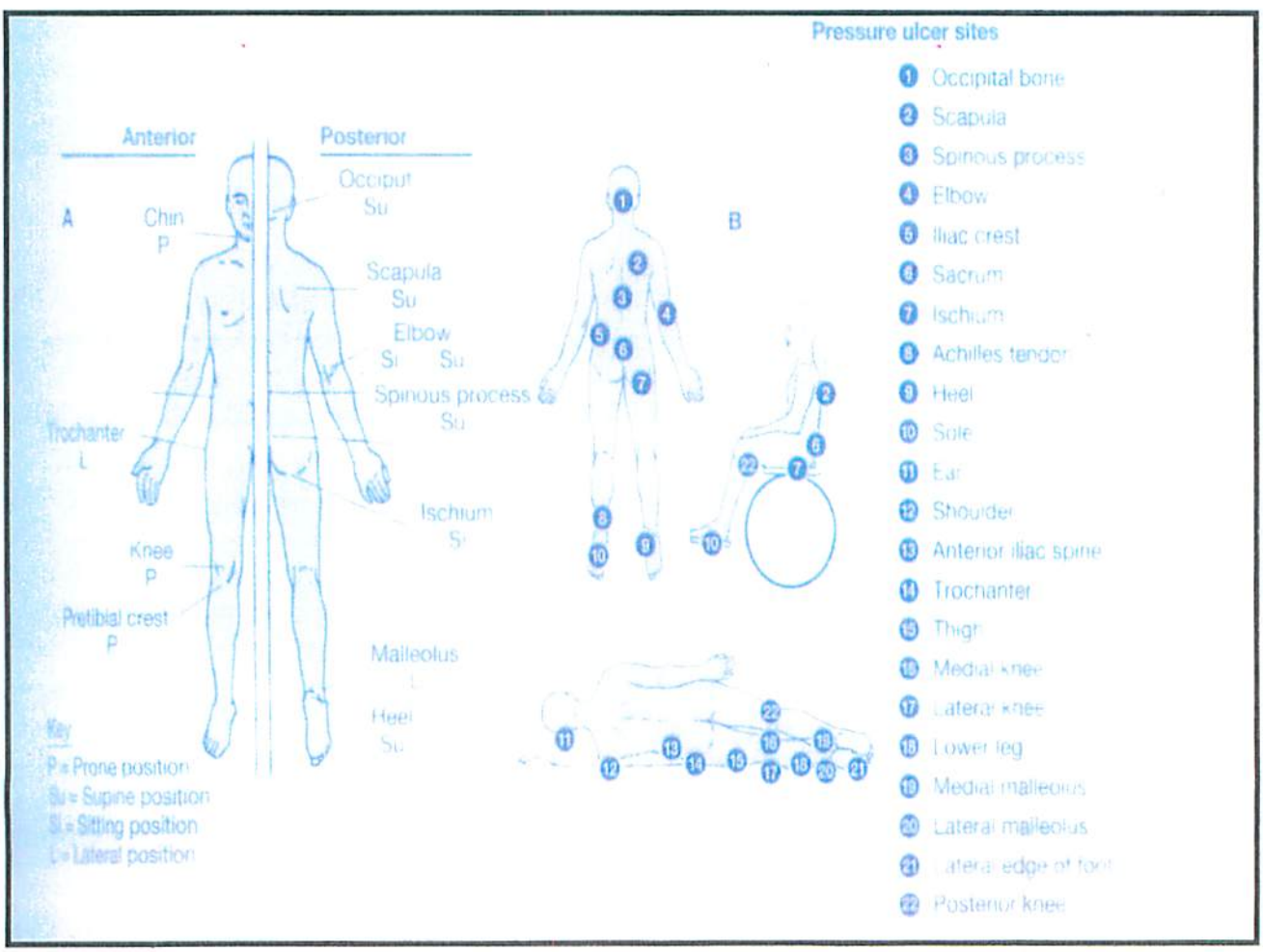
Pressure ulcers may occur initially in the superficial layers of the skin.

Stage I: Discoloration of intact skin, including non-blancheable erythema, blue/purple and black discoloration.

Stage II: Partial-thickness skin loss involves epidermis and/or dermis. Ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater.

Stage III: Full-thickness skin loss involves damage or necrosis of subcutaneous tissues; but not through the underlying fascia and not extending to the underlying structures.

Stage IV: Full-thickness skin loss occurs with extensive destruction, and tissue necrosis extending to the underlying bone, tendon or joint capsule.



Points to Ponder

BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK

A person with a total score of 16 or less is considered to be at risk of developing pressure ulcers.
(15-16 = low risk; 13-14 = moderate risk; 12 or less = high risk)

Patient's Name _____ Evaluator's Name_____ Date of Assessment_____

SENSORY PERCEPTION ability to respond meaningfully to pressure-related discomfort	**1. Completely Limited** Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation. OR limited ability to feel pain over most of body	**2. Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over ½ of body.	**3. Slightly Limited** Responds to verbal commands, but cannot always communicate discomfort or the need to be turned. OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	**4. No Impairment** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.	**SCORE**
MOISTURE degree to which skin is exposed to moisture	**1. Constantly Moist** Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	**2. Very Moist** Skin is often, but not always moist. Linen must be changed at least once a shift	**3. Occasionally Moist:** Skin is occasionally moist, requiring an extra linen change approximately once a day.	**4. Rarely Moist** Skin is usually dry, linen only requires changing at routine intervals.	**SCORE**
ACTIVITY degree of physical activity	**1. Bedfast** Confined to bed.	**2. Chairfast** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	**3. Walks Occasionally** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	**4. Walks Frequently** Walks outside room at least twice a day and inside room at least once every two hours during waking hours	**SCORE**
MOBILITY ability to change and control body position	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance	**2. Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	**3. Slightly Limited** Makes frequent though slight changes in body or extremity position independently.	**4. No Limitation** Makes major and frequent changes in position without assistance.	**SCORE**
NUTRITION usual food intake pattern	**1. Very Poor** Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and/or maintained on clear liquids or IVs for more than 5 days.	**2. Probably Inadequate** Rarely eats a complete meal and generally eats only about 1/2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement. OR receives less than optimum amount of liquid diet or tube feeding	**3. Adequate** Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs.	**4. Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	**SCORE**
FRICTION & SHEAR	**1. Problem** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction.	**2. Potential Problem** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	**3. No Apparent Problem** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair		**SCORE**

TOTAL SCORE _____

Division of Mental Retardation

May 2002

Best Practice Guidelines

Nutritional Management for Individuals with Complex Needs

Special points of interest:

- General Guidelines for Seizure Management
- Anticipated Outcomes
- Special Focal Points
- Points to Ponder

Inside this Issue:

Section I. 1
Overview : Nutritional management for individuals with complex needs.

Section II. 2
Observational guidelines.
A. Health assessments
B. Individual with recurrent aspiration pneumonia 3
C. Care of individual with a gastrostomy tube 3

Section I. Overview:

Nutritional wellness is aimed toward establishing positive health through positive eating habits. Each individual must benefit from a program that is most appropriate for his or her capability. Because of the large number of individuals with mental retardation/developmental disabilities who have nutritional disorders, work-ups of the nutritional disorders are frequently warranted.

Gastroesophageal reflux with vomiting, rumination, and esophageal irritation is one of the most commonly occurring conditions leading to nutritional management problems.

The Interdisciplinary Team should strive to provide the individual with the needed nutritional support, to promote wellness and increase quality of life, as well as to enhance the individual's chances for recovery from other co-existent diseases. Although it may be easy to identify the severely malnourished individual, the individual with subtle malnutrition is difficult to recognize.

Aspiration pneumonia is an acute inflammation of the alveoli and interstitium due to the invasion of the lungs by food or fluids from the mouth; or food or fluids regurgitated or refluxed from the stomach back into the esophagus, into the posterior pharynx, and then into the lung field. Regardless of the causative organism or agent, pneumonia produces dyspnea, tachypnea, fever, coughing, and chronic effects including fibrotic changes or scarring, decreased lung capacity, and ineffective air exchange. Nutrition is challenged.

Anticonvulsants and other medication may depress the nervous system, decreasing overall body tone. This loss of body tone and alertness may increase swallowing difficulty.

Swallowing problems in some individuals may result from behavior patterns, PICA, narcoleptic induced movement disorders, paralytic conditions, or medical diagnoses. The consequences may be aspiration pneumonia or airway obstruction resulting in sudden death.

Anticipated Outcomes of Nutritional Management

1. All individuals will have their nutritional needs, desired weight, and nutritional status clearly identified to ensure alignment with their overall level of health.

2. Individuals with defined risk or actual alteration in nutritional status will have a written preventive plan of nursing care included in their annual assessment.

3. Documentation will serve as a reliable source of information and as an effective means of communication to all staff members involved in the nutritional management of the individual.

Section II. Observational Guidelines:

A. Health assessments

The annual health assessment by the health care team will include observations for signs and symptoms associated with nutritional disorders. Data to be observed will include, but not be limited to:

The guidelines say...

a. Height and weight
b. Body frame size
c. Recurrent wheezing
d. Reduced resistance to infection
e. Muscle weakness or atrophy
f. Poor caloric intake
g. Skin changes
h. Choking, coughing at mealtime
i. Unexplained weight loss or gain
j. Recurrent vomiting
k. Poor wound healing
l. Excessive hair shedding
m. Signs of gastroesophageal reflux or rumination
n. Unexplained or recurrent upper respiratory infection or low grade fevers
o. Tardive dyskinesia
p. Drooling
q. Fever of undetermined origin

A nutritional plan of management will be formulated for those individuals with defined alterations in nutritional status by the interdisciplinary team with input from the Registered Nurse or the Licensed Practical Nurse.

Points to Ponder

Research data are showing increasing evidence of the importance of nutrition in health maintenance and disease prevention.

Nutrition is a basic component of all aspects of health. It is essential for normal growth, tissue maintenance and repair, and recovery from illness or surgery. An adequate supply of nutrients is needed for basic body cells to the special antibodies and cells of the immune system.

The body requires food to provide energy for organ function, body movement, and daily activities, to maintain body temperature, and to provide raw materials for enzyme function, growth, replacement of body tissues, and repair.

Cardiovascular diseases, diabetes, cancer, and obesity are major diseases of our population that may be treated or prevented by optimal nutrition.

Observational Guidelines continued:

B. Individual with recurrent aspiration pneumonia

A complete respiratory systems review is needed to assess for aspiration pneumonia.

Anticipated Outcomes
For Individual with Recurrent Aspiration Pneumonia

All members of the interdisciplinary team will be aware of the specific issues relating to aspiration pneumonia that may require their involvement in recognition, follow-up, and monitoring.

Appropriate diagnostic measures and therapies will be utilized until the problem is resolved as directed by the primary health care provider.

A comprehensive treatment plan will be formulated to include all appropriate interventions, the individual's response, and expected outcomes.

Documentation will occur from identification of symptoms throughout the course of the illness.

Guidelines for Individual with Recurrent Aspiration Pneumonia.

1. Frequent assessments by the nurse will include full vital signs to include oxygen saturation if appropriate and a thorough abdominal and respiratory systems review. Other systems will be reviewed as indicated by observed symptoms.
2. The physician must be immediately notified of all significant clinical changes.
3. Nursing interventions for preventing aspiration risks for the individual with a nasogastric tube in place include:
   - Check tube placement before each use
   - Elevate head of bed at least 30º during feeding and for one-half to one hour after eating
   - Feed slowly until tolerance is determined
   - Stop feeding one-half to one hour before returning to recumbent position
   - Check gastric residual before feeding; delay feeding if residual is greater than 100-150 cc or 10-20% of hourly flow rate. (Individuals who have problems with residual should have an established protocol for intervention or as directed by the primary health care provider in accordance with facility policy.)
   - Check for other signs of decreased gastric motility (e.g., decreased bowel sounds and abdominal percussion of air.)
   - Assess vital signs and breath sounds for signs of actual aspiration
4. Fever of unknown origin should be suspected to be respiratory in cause until proven otherwise.

C. Care of individual with a gastrostomy tube

Anticipated Outcomes
For Individual with a Gastrostomy Tube

The nurse, as part of the interdisciplinary team, will evaluate compliance with the established goals and objectives for the gastrostomy feed.

Observational Guidelines continued:

Care of individual with a gastrostomy tube continued:

Guidelines for Individual with a Gastrostomy Tube

Placement of a gastrostomy tube may be indicated for the following medical conditions:

- Failure of aggressive medical therapy
- Recurrent aspiration pneumonia
- Recurrent esophageal bleeding
- Persistent anemia due to esophageal blood loss, severe depression, psychosis, or anorexia nervosa not responding to treatment for a significant duration which compromises the nutritional status of the individual
- Malabsorption, unremitting vomiting behavior
- Severe neurological problems
- Protein-calorie malnutrition with inadequate oral intake
- Swallowing disorders non-responsive to treatment
- Esophageal obstruction

Points to Ponder

Common Laboratory Tests to Evaluate Nutritional Status

Serum albumin level (normal: 4-5.5 mg/100 ml)	maintains serum protein levels; maintains fluid and electrolyte balance; determines prolonged protein wasting
Prealbumin level (normal 17-40 mg/dL)	indicates declining nutritional status; more useful for detecting short-term nutritional status then albumin
Transferrin level (normal: 170-250 mg/100 ml)	more specific indicator of protein-calorie malnutrition than albumin (blood protein binds with iron)
Total lymphocyte count (normal: >1800)	reflects depression of immune system caused by impaired nutritional intake
Hemoglobin level (normal: 12-15 g/100 ml)	measures oxygen and iron-carrying capacity of blood
Blood urea nitrogen level (normal: 10-20 mg/100 ml)	measures breakdown of dietary protein; measures urea production in liver and excretion in kidneys; it may be low in individuals with low muscle mass or muscle atrophy
Creatinine execration in 24-hour urine (normal: 0.6-1.3 mg/100 ml for men and 0.5-1.0 mg/100 ml for women)	reflects total muscle mass; indirectly measures skeletal muscle mass depletion

Observational Guidelines continued:

Care of individual with a gastrostomy tube continued:

Post Gastrostomy Care will Include:

1. Infusion via a volumetric pump (hours of infusion should be carefully considered to allow the individual more freedom and normalcy of activities).
2. Gastrostomy site should be checked for signs of infection at least on a daily basis (follow facility policy as indicated).
3. Placement of the tube should be assessed prior to infusion.
4. Head of bed will be elevated 30º or more during infusion by the use of blocks under the head of the bed (follow facility policy to determine type of block to be used).
5. Respiratory and abdominal nursing assessments should be done at least once per shift for new gastrostomy feedings and when indicated for identified problems.
6. The tube should be flushed with the prescribed amount of water to ensure tube patency.
7. Check for residual at least every eight hours, notify the health care provider if the residual is 150 cc or greater, or as specified by the physician's order.
8. The individual must remain in the upright position at least 30-60 minutes following the feeding unless otherwise prescribed.
9. Encourage oral intake **only when indicated and ordered by the physician.**
10. Assessment for bowel management program to prevent impaction.
11. Restraints, if used to safeguard the individual, will be addressed by the interdisciplinary team and be time limited with a plan for reduction in their use (follow facility policy).

Points to Ponder

Historically, large-bore tube placement has been verified by one of three techniques: withdrawing gastric contents from the tube, injecting air through the tube while auscultating the stomach for a gurgling or bubbling sound, and asking the individual to speak (nasogastric tube). These methods do not apply as readily to small-bore nasogastric tubes. The literature suggests that aspiration of stomach contents from small-diameter tubes is not always possible because the negative pressure that is created causes the tube to collapse on itself.

The inability to satisfactorily measure gastric contents by gastric aspiration into a syringe interferes with the ability to measure gastric retention of the feeding. Thus it becomes even more important to assess the individual for abdominal distention, nausea, and vomiting. Failure to note a markedly dissented abdomen increases the individual's risk for regurgitation and aspiration of gastric contents. The head of the bed needs to be elevated to prevent pulmonary aspiration.

If the individual reports respiratory difficulty, such as shortness of breath and coughing, document that the tube feeding was stopped and notify the physician at once. These signs and symptoms indicate that aspiration has occurred or pneumonia is developing.

Observational Guidelines continued:

Points to Ponder continued

Nasogastric Tubes

Because of the difficulty in withdrawing fluid from small-bore feeding tubes, nurses frequently rely on the auscultatory method to confirm nasogastric tube placement. This method consists of insufflating 10-30 ml of air through the tube while auscultating the epigastrium or left upper quadrant for gurgling or bubbling. Yet, numerous sources in the literature report that "pseudo-confirmatory gurgling" can occur when the tube is elsewhere such as in the esophagus or lung. Nurses were unable to determine gastric tube location by the auscultatory method. For example, the nurses reported hearing air when the tube was located in the esophagus, duodenum, jejunum, and stomach.

Little has been written of how the nurse should check for placement of small-bore nasointestinal feeding tubes. Nurses in practice frequently report using the auscultatory method, even though its reliability has been questioned.

The most reliable method is radiographic verification. This method is costly and has some risk from repeated exposure to x-ray equipment. Therefore new methods to test placement such as pH testing are being researched. In the meantime, the nurse must use meticulous assessment skills to find tube displacement.

Gastrostomy Tubes

A gastrostomy feeding tube is a long, hollow, flexible tube inserted into the stomach through a surgical stoma inserted in the upper left abdominal quadrant. Also known as a G-tube. A G-tube inserted under endoscopic guidance, known as a percutaneous endoscopic gastrostomy tube (PEG), contains internal and external crossbars, called bumpers, that anchor the tube. Can migrate or become dislodged.

Follow manufactures recommendations and physician orders for the best method to check for gastric residual. Some tubes may have a valve that requires a specialized instrument to aspirate stomach contents. Presence of gastric contents indicates that the end of the tube is in the stomach. Gastric residual determines whether gastric emptying is delayed. Return the aspirated stomach contents prior to beginning the feeding.

Auscultate over left upper quadrant with stethoscope and inject 10-20 ml of air into tube. A whooshing or gurgling sound can be heard entering the stomach. The insertion of too much air will result in abdominal discomfort for the individual.

Tube must be flushed with prescribed amount of water after each use (feeding, or medication administration). All medications that require crushing must be thoroughly pulverized to avoid clogging the tube. Follow facility policy and physician orders concerning the flushing of the tube.

Observational Guidelines continued:

Points to Ponder continued

Jejunostomy Tubes

A jejunal feeding tube is a large-bore tube surgically inserted into the jejunum for the administration of liquified nutrition. Also called a J-tube.

Much like the gastrostomy tube, follow manufactures recommendations and physician orders for the best method to check for gastric residual. The aspiration method may be prohibited due to the location of the tube. The most reliable method is radiographic verification.

Displacement is associated with risk factors such as coughing, vomiting, and appearance at the insertion site of markings that indicate the tube position. Can migrate or become dislodged.

Percutaneous Endoscopic Jejunostomy Tubes

There are several variations on the PEG technique. One of them is the PEG/PEJ (percutaneous endoscopic gastrostomy/percutaneous endoscopic jejunostomy). This technique involves placing a short PEG tube in the usual transgastric position. Through the lumen of that PEG tube, a thinner jejunostomy tube is placed. The jejunostomy tube then traverses the pylorus and extends down beyond the ligament of Treitz. Direct tube feeding at the jejunum is then possible. Also known as a PEJ tube, it is actually a smaller tube that is passed through the PEG tube into the small intestine.

All tubes require daily assessments. Follow manufacturer directions for replacement and directions on how to obtain residuals. Follow physician orders concerning rate of administration, and amount of flush after each use. Tube replacement is determined on an individual basis, requires a physician order, and following the manufacturer recommendations. Verification of placement is determined by type of tube inserted and by physician recommendation. Follow facility policy for tube replacement and verification method to be used. When problems occur, they are reported promptly, and changes are made to the plan for care.

Division of Mental Retardation

May 2002

Best Practice Guidelines

Medication Administration

Special points of interest:

- General Guidelines for Medication Administration
- Anticipated Outcomes
- Special Focal Points
- Points to Ponder

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Section I. Overview:

The nurse administering medications is accountable for knowing what medications are prescribed, their therapeutic and nontherapeutic effects, and the individual's needs and abilities. Nurse practice acts define and set limits on the scope of a nurse's professional functions and responsibilities in giving medications.

The nurse assesses the individual's ability to self-administer drugs, determines whether an individual should receive a drug at a given time, administers drugs correctly, and monitors the effects of prescribed drugs. Education about proper drug administration and monitoring is an integral part of the nurse's role. The nurse uses the nursing process to integrate drug therapy into care.

The nurse organizes care activities to ensure the safe administration of drugs. Undue haste can cause errors. A registered nurse checks all transcribed orders against the original order for accuracy and thoroughness. The nurse who gives the wrong medication or an incorrect dose is legally responsible for the error.

The nurse follows the "rights" of drug administration. These include: the *right* drug; the *right* dose; the *right* individual; the *right* route; the *right* time; and for some individuals the *right* position; and the *right* texture or consistency.

The nurse will follow facility policy regarding the form used to represent the MAR (medication administration record), form used to record the location of injection site, form used for refusal of medication, form used to report adverse effects of medication, form used to report a medication error, and form used when an individual is undergoing tests or a procedure that results in a missed dose.

No medication is to be given without an order. Only facility approved abbreviations are to be used. In some situations such as an emergency, a health care provider may order a medication by telephone or by giving the nurse a verbal order. Most facilities require a health care provider's signature within 24 hours after the order is made.

Anticipated Outcomes of Medication Administration

1. All individuals will gain therapeutic effect of the prescribed medications without discomfort or complications.
2. Individuals will have no complications related to the route of administration.
3. Documentation will serve as a reliable source of information of appropriate medication administration.

Section II. Types of orders:

The nurse does not have sole responsibility for drug administration. The health care provider and the pharmacist also help to ensure the right medication gets to the right person. A history of medication allergies and food allergies should also be carefully documented because many drugs have ingredients found in food sources.

The physician prescribes the individual's drugs (unless a state's nurse practice act allows nurse practitioners or other advance practice nurses to prescribe under collaborative agreements). The physician writes an order on a form in the individual's medical record, in a physician's order book, on a legal prescription pad, or through a computer terminal. Under emergency conditions a verbal or telephone order may be given to the nurse, and the order signed by the physician within 24 hours.

A. Regularly scheduled medicine orders

The physician writes prescriptions for individuals who are to take drugs outside the hospital. The prescription includes detailed information so the individual understands how to take the drug and when to refill the prescription if necessary. These are routine drugs usually taken on a daily basis. Medications are given until the specified number of doses has been administered or until the order has expired or has been canceled.

The parts of a prescription may include:

- The individual's name, address, age and date are given for identification purposes.
- The drug name, route, strength and dose.
- Directions regarding the number of tablets or amount to be dispensed are given to the pharmacist.
- The physician signs the prescription, if the drug is a controlled substance, the physician includes his or her registration number and address.
- Directions to the individual to include any restrictions (time, refrigeration, food or drug) and directions for refilling the prescription.

Points to Ponder

Essential Components of Drug Orders.

Full Name: this information distinguishes the individual from other persons with the same last name.
Date and Time Order is Written: the day, month, year, and time are included. Designating the time an order is written helps to clarify when certain orders are to automatically stop. If an incident involving a drug error occurs, it will be easier to document what happened when this information is available.
Drug Name: the physician usually orders a generic or trade-name drug. Correct spelling is essential in differentiating names with similar spelling.
Dosage: the amount and strength of the drug is included. Special information for giving the drug may be included.
Route of Administration: the physician uses common abbreviations for drug routes. Accuracy is important because certain drugs are given more than one route.
Time and Frequency of Administration: the nurse needs to know when to start drug therapy and how often the drug will be administered.
Signature of Physician or Nurse Practitioner: the signature makes the order a legal request.

Types of orders continued:

B. PRN orders

The physician may order a drug when an individual requires it. This is a prn order. The nurse uses discretion in determining the individual's need. Often the physician sets maximum intervals for the time of administration. These drugs are to be given only under specific circumstances as indicated by the physician's orders.

The nurse assesses the individual prior to administration, and monitors the effects of the drug. The nurse must be aware of the purpose, action, and potential undesired effects of the drug administered. The nurse reports effectiveness of the drug according to facility policy.

C. Single (one-time) orders

A physician will often order a drug to be given only once at a specified time. This is common for preoperative drugs or drugs given before diagnostic examinations. Follow the directions exactly as written. Monitor the effectiveness of the drug and report positive or negative responses to the prescribed medication.

All medications require an order from a health care provider.

D. STAT orders

STAT order signifies that a single dose of a medication is to be given immediately and only once. STAT orders are often written for emergencies when the individual's condition changes suddenly.

The nurse will monitor the individual and report positive or negative findings to the physician according to facility policy. The condition of the individual will be monitored and charted until the individual returns to baseline.

E. Standing orders

A standing order is carried out until the physician cancels it by another order or until a prescribed number of days elapse. A standing order may indicate a final date or number of treatments or dosages. Many facilities have policies for automatically discontinuing standing orders. Read labels carefully and follow all instructions.

The nurse must have the necessary knowledge and skill to satisfy the responsibilities of safe and effective drug administration. The individual is not to receive unnecessary medications. Report any negative reactions to the physician immediately.

Section III. Nursing process:

A. Assessment

To determine the need for and potential response to drug therapy, the nurse assesses many factors.

- √ Medical history—a medical history provides indications or contraindications for drug therapy. Diseases or illness may place an individual at risk for adverse drug effects.
- √ History of allergies—all allergies should be noted on the nurse's admission notes, medication records, and physician's history.
- √ Drug data—information about each drug, including action, purpose, normal dosages, routes, side effects, and nursing implications for administration and monitoring.
- √ Diet history— a diet history reveals normal eating patterns and food preferences. The nurse can then plan the dosage schedule more effectively and advise the individual in avoiding foods that may interact with medications.
- √ Individual's current condition—the ongoing physical or mental status of an individual may affect whether a drug is given or how it is administered; if an individual is capable of self-administration; if conditions exist such as impaired swallowing. Assessment findings also serve as a baseline in evaluating the effects of drug therapy.
- √ Knowledge and understanding of drug therapy—this influences the willingness or ability to follow a drug regimen. By assessing the individual's knowledge about a medication, the nurse determines the need for instruction concerning the drug regimen.

B. Transcription

Orders must be checked for accuracy.

Each time an order is transcribed there is potential for error. When transcribing orders be sure the names, dosages, and symbols are legible. Rewrite any smudged or illegible transcriptions.

The nurse or a designated person (determined by facility policy) writes the physician's complete order on the appropriate medication forms. The transcribed order includes the individual's name, drug name, dosage, frequency, route, and any special precautions to be observed during administration. A registered nurse (or as directed by facility policy) checks all transcribed orders against the original order for accuracy and thoroughness. If an order seems incorrect or inappropriate, the nurse consults the physician. The nurse who gives the wrong medication or an incorrect dose is legally responsible for the error.

In some facilities a computer printout lists all currently ordered medications with dosage information. Orders are entered directly into the computer, preventing the need for transcription of orders. The same printout may be used to record medications given. A nurse is still required to verify the information against the original order for accuracy.

Nursing process continued:

C. Dosage and measurement

When measuring liquid drugs, the nurse uses standard measuring containers. The procedure for drug measurement is systematic to lessen the chance of error. The nurse calculates each dose when preparing the drug, pays close attention to the process of calculation, and avoids interference from other activities.

Each facility will determine choices of appropriate measuring devices to be used for liquid medications.

D. Safe administration

For safe administration, the nurse uses aseptic technique and proper procedures when handling and giving medications. Promoting comfort (e.g., positioning) increases efficiency. Certain drugs require the nurse to perform assessments (e.g., assessing heart rate prior to giving antidysrhythmics). Developmental level of the individual may be a factor in the way a nurse administers medications. The nurse uses guidelines to ensure safe drug administration. These guidelines include:

- ⇒ the *right* drug
- ⇒ the *right* dose
- ⇒ the *right* individual
- ⇒ the *right* route
- ⇒ the *right* time
- ⇒ for some individuals the *right* position
- ⇒ and the *right* texture or consistency

Points to Ponder

Keep each drug in its original labeled container.

Protect drugs from exposure to heat and light, as required.

Check that labels are legible.

Discard outdated medications.

Always finish a prescribed drug unless otherwise instructed and never save a drug for future illnesses.

Dispose of drugs in sink or toilet (per facility policy) and never place drugs in the trash within reach of others.

Never give anyone a drug prescribed for another individual.

Refrigerate drugs that require it.

Read labels carefully and follow all instructions.

Notify health care provider of side effects.

Nursing process continued:

E. Recording drug administration

After administering a drug, the nurse records it immediately on the appropriate record form. **The nurse never charts a drug before administering it**. Recording immediately after administration prevents errors.

The recording of a drug includes the name of the drug, dosage, route, and exact time of administration. Often the drug forms are prepared and the nurse need only record the time. Facility policy may also require that the nurse record the location of an injection.

When an individual refuses a drug or is undergoing tests or procedures that result in a missed dose, the nurse explains the reason the drug was not given in the nurse's notes. Some facilities require the nurse to circle the prescribed administration time on the drug record when a dose is missed.

Above all, learn—and follow—your facility's policies and procedures for drug administration.

F. Individual and caregiver teaching

Teaching the individual and caregivers about prescribed medications can promote adherence to the regimen and foster independence. The nurse, as an advocate, is also responsible for knowing about the medications and determining if they may adversely affect the individual, especially if there are multiple prescriptions.

Unless an individual is properly informed about drugs, he or she may take the drugs incorrectly or not at all. Caregivers as well as the individual should be informed of drug side effects because they are often the first persons to recognize side effects or problems caused by drugs. Everyone should learn the basic guidelines for drug safety.

G. Maintaining individual's rights

In accordance with the Patient's Bill of Rights and because of the potential risks related to drug administration, an individual has the right to:

1. be informed of drug name, purpose, action, and potential undesired effects
2. refuse a medication and be informed of the consequences
3. have qualified nurses and physicians assess a drug history, including allergies
4. be properly advised of drug therapy and to give written consent for its use (per facility policy)
5. receive labeled medications safely without discomfort in accordance with the "rights" of drug administration
6. receive appropriate supportive therapy in relation to drug therapy
7. not receive unnecessary medications

A nurse should not become defensive if an individual refuses drug therapy. The nurse must have the necessary knowledge and skill to satisfy the responsibilities of safe and effective drug administration.

Section IV. Medication delivery:

A. Right drug

The pharmacy should fill the prescription as ordered.

When drugs are first ordered, the nurse compares the MAR (medication administration record) or computer orders with the health care providers written orders. When administering drugs, the nurse compares the label of the drug container with the MAR. The nurse does this three times: (1) before removing the container from the drawer or shelf, (2) as the amount of drug ordered is removed from the container, and (3) before returning the container to storage. With unit-dose prepackaged drugs, the nurse checks the label with the MAR a third time even though there is no permanent container. Unit-dose medications may be checked before opening at the individual's bedside.

The nurse administers only the drugs **they** prepare. If an error occurs, the nurse who administers the drug is responsible for its effects. If an individual questions the medication a nurse prepares, it is important not to ignore these concerns. The individual's questions might reveal an error.

Individual's who self-administer drugs should keep them in their original labeled containers, separate from other drugs, to avoid confusion. Follow facility policy concerning storage of medications for safety.

The nurse never prepares medications from unmarked containers or containers with illegible labels. If an individual refuses a drug, the nurse should discard it rather than return it to the original container (follow facility policy). Unit-dose packaged drugs can be saved if they are unopened.

B. Right dose

The nurse prepares the drug using the standard measuring devices. Graduated cups, syringes, and scaled droppers can be used to measure medications accurately. At home, individuals should use kitchen measuring spoons rather than teaspoons and tablespoons, which vary in volume.

When a drug must be prepared from a larger volume or strength than needed or when the drug comes in a measurement different from what the pharmacist supplied, the chance of error increases. When it is necessary to break a scored tablet (always request pharmacy to perform this procedure), the break should be even. Tablets that do not break evenly are discarded. Tablets that are not scored are not to be divided, as this may result in under or over dosing the individual.

Scored tablets must be broken evenly for proper dosage.

When a nurse prepares a tablet by crushing it so that it can be mixed in food, the crushing device should always be cleaned completely before the tablet is crushed. Remnants of previously crushed drugs may increase a drug's concentration or result in the individual receiving a portion of an unprescribed drug. Crushed medications should be mixed with very small amounts of food or liquid. The individual's favorite foods or liquids should not be used because a medication may alter their taste and decrease the individual's desire for them.

The composition of a drug is designed to enhance its absorption and metabolism. Check with the health care provider or pharmacy before breaking or crushing tablets, or opening capsules.
Not all medications can be chewed, crushed, broken, or "opened."

Medication delivery continued:

C. Right individual

An important step in administering drugs safely is being sure the drug is given to the right person. It is difficult to remember every persons name and face. Follow facility policy for identification procedures. Often the MAR will include a recent, dated photograph of the individual with their name clearly indicated on the photo. Some facilities may use an identification bracelet. Never assume that merely speaking the name of a person indicates that he or she is the correct person. Some individuals may become confused and respond incorrectly.

D. Right route

If a health care provider's order does not designate a route of administration, the nurse consults the physician. Likewise, if the specified route is not the recommended route, the nurse should alert the physician immediately.

When the nurse administers injections, precautions are necessary to ensure that the drugs are given correctly. It is also important to prepare injections only from preparations designed for parenteral use. The injection of a liquid designed for oral use can produce local complications, such as a sterile abscess, or fatal systemic effects. Drug companies label parenteral drugs for "injectable use only." Always chart the exact location of the injection given.

Medications given through a nasogastric tube, J-tube, G-tube, or small-bore feeding tube require specific orders indicating the preparation of the drug and the amount of water to follow the preparation. Administer medications in a liquid form when possible to prevent tube obstruction. Do not attempt to give whole or undissolved medications by this route.

E. Right time

The nurse must know why a drug is ordered for certain times of the day and whether the time schedule can be altered. Each facility has a recommended time schedule for medications ordered at frequent intervals. At home an individual may have to take several medications throughout the day. The nurse helps to plan schedules based on preferred drug intervals and the individual's daily schedule.

Every 8 hours, or t.i.d., there is a difference.

The physician often gives specific instructions about when to administer a medication. A preoperative medication to be given on call means that the nurse is to administer the drug when the nurse is notified by the operating room. A drug ordered "pc" (after meals) is to be given within half an hour after a meal when the individual has a full stomach. A "stat" medication is to be given immediately. The physician intends the q8h medication to be given around the clock to maintain therapeutic blood levels. In contrast, the t.i.d. medication is given during the waking hours.

Drugs that must act at certain times are given priority. For example, insulin should be given at a precise interval before a meal. All routinely ordered medications should be given within 30 minutes of the times ordered (30 minutes before or after the prescribed time).

Some drugs require the nurse's clinical judgment in determining the proper time for administration. For example, a "prn" sleeping medication should be administered when the individual is prepared for bed. A nurse also uses judgment when administering "prn" analgesics (e.g., Tylenol 650 mg PO q **4-6h** prn).

Medication delivery continued:

F. Right position

Protect individuals against aspiration through positioning in sitting or side-lying position. Follow the health care providers recommendation for the proper positioning of an individual to prevent liquid or solid medication from accumulating in the back of the throat. Some individuals require specific techniques related to swallowing to prevent aspiration. Follow facility policy on recommended positions.

G. Right texture or consistency

Oral and motor difficulties are significant considerations.

Some individuals may have oral and motor difficulties requiring special techniques for medication administration. The dining plan can be used to determine the best method to be used for medication administration. It is important to consider food-drug interactions and the amount, texture, temperature, and consistency of the substance swallowed.

Texture is how coarse or fine a substance is created. It may be necessary to chop the food being used as the vehicle for the medication into the right size or select another vehicle. An individual can be easily choked if the texture is not correct.

Consistency is a food's firmness or density. An individual can have problems swallowing medication that has been placed in a food being used as the vehicle that is too sticky, too runny, too wet, or too dry.

Follow the recommendations of the oral motor specialists when giving medications to individuals with oral and motor difficulties.

Section V. Storing medications:

Despite legislative controls, some people use drugs for reasons other than their prescribed purpose. Guidelines for safe administration and control of controlled substances and narcotics have been established. Facilities establish individual policies that must meet federal, state, and local regulations. The size of the facility, the types of services it provides, and the types of professional personnel it employs influence policies. The nurse is responsible for following legal provisions when administering controlled substances or narcotics, which are carefully controlled through federal and state guidelines. Violations of the Controlled Substances Act are punishable by fines, imprisonment, and loss of nurse licensure.

Hospitals and other health care facilities have policies for the proper storage and distribution of controlled substances and narcotics. In each facility there is one area where drugs are stored. Some facilities keep medications in a mobile cart, whereas others may store them in a separate room. Each individual has a separate drawer or cubicle in which their prescribed medications are kept. Regardless of their location, medications are kept locked until they are administered. Narcotics are controlled substances. In health agencies, narcotics are kept in a *double-locked* drawer, box, or room. A record is kept of each narcotic that is used. Narcotics are counted at each change of shift. The nurse going off duty counts all controlled substances and narcotics with the nurse coming on duty. Both nurses sign the record to indicate that the count is correct. This record provides an accurate, ongoing count of medications used and remaining. Discrepancies in counts are reported immediately.

Storing medications continued:

Medications are stored individually for each person and separately from food and supplies. Each individual's medication is stored in a container labeled for that particular person. Medication must not be stored with any other items. Medications to be applied externally are separated from medications to be taken internally. The individual's internal and external medication are stored in separate containers. Ideally, the containers should have clearly marked labels indicating whether the medication is for external or internal use. If medication is to be refrigerated, it must be kept separate from food. Oral, injectable, and/or rectal medication is stored separately from other medication.

All medications are stored securely and only authorized persons have access to the storage area keys, if these are used, unless otherwise warranted by the living situation. The facility evaluates the drugs used by the person who receives services and develops a plan for security accordingly. For persons who are not self administering, medications are stored in such a manner so that the person and/or roommate could not accidentally ingest. Scheduled drugs should be stored under lock and key so as to not only prevent accidental ingestion by the person but also to prevent abuse by others. For individuals self administering, the medication should be stored in a location convenient for them to use but secure enough so that roommates could not accidentally ingest.

Discontinued medications are disposed of according to facility policy. Prescription medications are accessible at all times to appropriate persons. Prescription medications are transported by staff in a prescription container with a pharmacy label. Medication is stored at the correct temperature. The thermometer in the refrigerator where medication is stored should register between 37 and 42 degrees F.

Facility must approve containers for storage of medications.

Section VI. Avoiding errors:

A medication error occurs when the wrong individual, the wrong drug, the wrong dose, the wrong route, the wrong time, the wrong position, or the wrong texture was used during the administration of medication. Medication errors do happen. Most medication errors occur when a nurse fails to follow routine procedures. Nurses have an ethical responsibility to report errors so that the individual's safety is maintained. As soon as an error is recognized, the individual's condition is checked and the mistake is reported to the physician and the appropriate supervisor immediately. Follow facility policy for reporting medication errors; usually an incident or accident report form. The incident or accident report form is not a part of the medical record, nor is any reference made in the medical record to the fact that an incident or accident form has been completed. The report provides an objective analysis of what went wrong and is a means of monitoring for the facility's risk management personnel. Without incident reports, supervisory personnel have difficulty in identifying errors and solving recurrent problems.

Avoiding errors continued:

Points to Ponder

WAYS TO PREVENT DRUG ADMINISTRATION ERRORS

PRECAUTION	RATIONALE
Read drug labels carefully.	Many products come in similar containers, colors and shapes.
Question administration of multiple tablets or vials for single dose.	Most doses are one or two tablets or capsules or one single-dose vial. Incorrect interpretation of order may result in excessively high dose.
Be aware of drugs with similar names.	Many drug names sound alike (e.g., digoxin and digitoxin, Keflex and Keflin, Orinase and Ornade).
Check decimal point.	Some drugs come in quantities that are multiples of one another (e.g., Coumadin in 2.5 and 25 mg tablets. Thorazine in 30 and 300 mg spansules).
Question abrupt and excessive increases in dosages.	Most dosages are made gradually so that physician can monitor therapeutic effect and response.
When a new or unfamiliar drug is ordered, consult resource.	If physician is also unfamiliar with drug, there is greater risk of inaccurate dosages being ordered.
Do not administer drug ordered by nickname or unofficial abbreviations.	Many physicians refer to commonly ordered medications by nicknames or unofficial abbreviations. If nurse or pharmacist is unfamiliar with name, wrong drug may be dispensed and administered.
Do not attempt to decipher illegible writing.	When in doubt, ask physician. Unless nurse questions order that is difficult to read, chance of misinterpretation is great.
Know individuals with same last name. Also have individuals state their full names. Check identification carefully.	It is common to have two or more individuals with same or similar last names. Special labels on Kardex or medication book can warn of potential problem.
Do not confuse equivalents.	When in a hurry, it may be easy to misread equivalents (e.g., milligram instead of milliliter).
Prepare medications under well lighted conditions.	Improves the ability to read labels accurately.
Check the expiration dates on drugs.	Ensures administration at desired potency.
Inspect the medication and reject those that appear to be decomposing in any manner.	Promotes appropriate absorption.

Avoiding errors continued:

Points to Ponder

MEDICATION/TREATMENT ERRORS AND OMISSIONS

NAME_____HOME/AGENCY_____
Date Error Discovered_____Time_____ByWhom_____
Medication or Treatment Involved

_____
_____
_____
_____

Description of Error in Detail (how discovered, effect on client, sequence of events, individuals involved)_____

_____
_____
_____
_____
_____
_____
_____

Name of Physician Notified_____Date & Time_____
By Whom_____
Physician's Instructions_____

_____
_____
_____

Physician's Signature _____Date & Time_____
Signature of Person Making Report_____Date & Time_____
Supervisor's Investigation_____

_____
_____
_____

Action Taken_____Date & Time_____

_____
_____
_____
_____

Signature of Supervisor_____Date & Time_____

Section II. Types of orders:

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Route of Administration: the physician uses common abbreviations for drug routes. Accuracy is important because certain drugs are given more than one route.
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A. Right drug

The pharmacy should fill the prescription as ordered.

When drugs are first ordered, the nurse compares the MAR (medication administration record) or computer orders with the health care providers written orders. When administering drugs, the nurse compares the label of the drug container with the MAR. The nurse does this three times: (1) before removing the container from the drawer or shelf, (2) as the amount of drug ordered is removed from the container, and (3) before returning the container to storage. With unit-dose prepackaged drugs, the nurse checks the label with the MAR a third time even though there is no permanent container. Unit-dose medications may be checked before opening at the individual's bedside.

The nurse administers only the drugs **they** prepare. If an error occurs, the nurse who administers the drug is responsible for its effects. If an individual questions the medication a nurse prepares, it is important not to ignore these concerns. The individual's questions might reveal an error.

Individual's who self-administer drugs should keep them in their original labeled containers, separate from other drugs, to avoid confusion. Follow facility policy concerning storage of medications for safety.

The nurse never prepares medications from unmarked containers or containers with illegible labels. If an individual refuses a drug, the nurse should discard it rather than return it to the original container (follow facility policy). Unit-dose packaged drugs can be saved if they are unopened.

B. Right dose

The nurse prepares the drug using the standard measuring devices. Graduated cups, syringes, and scaled droppers can be used to measure medications accurately. At home, individuals should use kitchen measuring spoons rather than teaspoons and tablespoons, which vary in volume.

When a drug must be prepared from a larger volume or strength than needed or when the drug comes in a measurement different from what the pharmacist supplied, the chance of error increases. When it is necessary to break a scored tablet (always request pharmacy to perform this procedure), the break should be even. Tablets that do not break evenly are discarded. Tablets that are not scored are not to be divided, as this may result in under or over dosing the individual.

Scored tablets must be broken evenly for proper dosage.

When a nurse prepares a tablet by crushing it so that it can be mixed in food, the crushing device should always be cleaned completely before the tablet is crushed. Remnants of previously crushed drugs may increase a drug's concentration or result in the individual receiving a portion of an unprescribed drug. Crushed medications should be mixed with very small amounts of food or liquid. The individual's favorite foods or liquids should not be used because a medication may alter their taste and decrease the individual's desire for them.

The composition of a drug is designed to enhance its absorption and metabolism. Check with the health care provider or pharmacy before breaking or crushing tablets, or opening capsules.
Not all medications can be chewed, crushed, broken, or "opened."

Medication delivery continued:

C. Right individual

An important step in administering drugs safely is being sure the drug is given to the right person. It is difficult to remember every persons name and face. Follow facility policy for identification procedures. Often the MAR will include a recent, dated photograph of the individual with their name clearly indicated on the photo. Some facilities may use an identification bracelet. Never assume that merely speaking the name of a person indicates that he or she is the correct person. Some individuals may become confused and respond incorrectly.

D. Right route

If a health care provider's order does not designate a route of administration, the nurse consults the physician. Likewise, if the specified route is not the recommended route, the nurse should alert the physician immediately.

When the nurse administers injections, precautions are necessary to ensure that the drugs are given correctly. It is also important to prepare injections only from preparations designed for parenteral use. The injection of a liquid designed for oral use can produce local complications, such as a sterile abscess, or fatal systemic effects. Drug companies label parenteral drugs for "injectable use only." Always chart the exact location of the injection given.

Medications given through a nasogastric tube, J-tube, G-tube, or small-bore feeding tube require specific orders indicating the preparation of the drug and the amount of water to follow the preparation. Administer medications in a liquid form when possible to prevent tube obstruction. Do not attempt to give whole or undissolved medications by this route.

E. Right time

The nurse must know why a drug is ordered for certain times of the day and whether the time schedule can be altered. Each facility has a recommended time schedule for medications ordered at frequent intervals. At home an individual may have to take several medications throughout the day. The nurse helps to plan schedules based on preferred drug intervals and the individual's daily schedule.

Every 8 hours, or t.i.d., there is a difference.

The physician often gives specific instructions about when to administer a medication. A preoperative medication to be given on call means that the nurse is to administer the drug when the nurse is notified by the operating room. A drug ordered "pc" (after meals) is to be given within half an hour after a meal when the individual has a full stomach. A "stat" medication is to be given immediately. The physician intends the q8h medication to be given around the clock to maintain therapeutic blood levels. In contrast, the t.i.d. medication is given during the waking hours.

Drugs that must act at certain times are given priority. For example, insulin should be given at a precise interval before a meal. All routinely ordered medications should be given within 30 minutes of the times ordered (30 minutes before or after the prescribed time).

Some drugs require the nurse's clinical judgment in determining the proper time for administration. For example, a "prn" sleeping medication should be administered when the individual is prepared for bed. A nurse also uses judgment when administering "prn" analgesics (e.g., Tylenol 650 mg PO q **4-6h** prn).

Medication delivery continued:

F. Right position

Protect individuals against aspiration through positioning in sitting or side-lying position. Follow the health care providers recommendation for the proper positioning of an individual to prevent liquid or solid medication from accumulating in the back of the throat. Some individuals require specific techniques related to swallowing to prevent aspiration. Follow facility policy on recommended positions.

G. Right texture or consistency

Oral and motor difficulties are significant considerations.

Some individuals may have oral and motor difficulties requiring special techniques for medication administration. The dining plan can be used to determine the best method to be used for medication administration. It is important to consider food-drug interactions and the amount, texture, temperature, and consistency of the substance swallowed.

Texture is how coarse or fine a substance is created. It may be necessary to chop the food being used as the vehicle for the medication into the right size or select another vehicle. An individual can be easily choked if the texture is not correct.

Consistency is a food's firmness or density. An individual can have problems swallowing medication that has been placed in a food being used as the vehicle that is too sticky, too runny, too wet, or too dry.

Follow the recommendations of the oral motor specialists when giving medications to individuals with oral and motor difficulties.

Section V. Storing medications:

Despite legislative controls, some people use drugs for reasons other than their prescribed purpose. Guidelines for safe administration and control of controlled substances and narcotics have been established. Facilities establish individual policies that must meet federal, state, and local regulations. The size of the facility, the types of services it provides, and the types of professional personnel it employs influence policies. The nurse is responsible for following legal provisions when administering controlled substances or narcotics, which are carefully controlled through federal and state guidelines. Violations of the Controlled Substances Act are punishable by fines, imprisonment, and loss of nurse licensure.

Hospitals and other health care facilities have policies for the proper storage and distribution of controlled substances and narcotics. In each facility there is one area where drugs are stored. Some facilities keep medications in a mobile cart, whereas others may store them in a separate room. Each individual has a separate drawer or cubicle in which their prescribed medications are kept. Regardless of their location, medications are kept locked until they are administered. Narcotics are controlled substances. In health agencies, narcotics are kept in a *double-locked* drawer, box, or room. A record is kept of each narcotic that is used. Narcotics are counted at each change of shift. The nurse going off duty counts all controlled substances and narcotics with the nurse coming on duty. Both nurses sign the record to indicate that the count is correct. This record provides an accurate, ongoing count of medications used and remaining. Discrepancies in counts are reported immediately.

Storing medications continued:

Medications are stored individually for each person and separately from food and supplies. Each individual's medication is stored in a container labeled for that particular person. Medication must not be stored with any other items. Medications to be applied externally are separated from medications to be taken internally. The individual's internal and external medication are stored in separate containers. Ideally, the containers should have clearly marked labels indicating whether the medication is for external or internal use. If medication is to be refrigerated, it must be kept separate from food. Oral, injectable, and/or rectal medication is stored separately from other medication.

All medications are stored securely and only authorized persons have access to the storage area keys, if these are used, unless otherwise warranted by the living situation. The facility evaluates the drugs used by the person who receives services and develops a plan for security accordingly. For persons who are not self administering, medications are stored in such a manner so that the person and/or roommate could not accidentally ingest. Scheduled drugs should be stored under lock and key so as to not only prevent accidental ingestion by the person but also to prevent abuse by others. For individuals self administering, the medication should be stored in a location convenient for them to use but secure enough so that roommates could not accidentally ingest.

Discontinued medications are disposed of according to facility policy. Prescription medications are accessible at all times to appropriate persons. Prescription medications are transported by staff in a prescription container with a pharmacy label. Medication is stored at the correct temperature. The thermometer in the refrigerator where medication is stored should register between 37 and 42 degrees F.

Facility must approve containers for storage of medications.

Section VI. Avoiding errors:

A medication error occurs when the wrong individual, the wrong drug, the wrong dose, the wrong route, the wrong time, the wrong position, or the wrong texture was used during the administration of medication. Medication errors do happen. Most medication errors occur when a nurse fails to follow routine procedures. Nurses have an ethical responsibility to report errors so that the individual's safety is maintained. As soon as an error is recognized, the individual's condition is checked and the mistake is reported to the physician and the appropriate supervisor immediately. Follow facility policy for reporting medication errors; usually an incident or accident report form. The incident or accident report form is not a part of the medical record, nor is any reference made in the medical record to the fact that an incident or accident form has been completed. The report provides an objective analysis of what went wrong and is a means of monitoring for the facility's risk management personnel. Without incident reports, supervisory personnel have difficulty in identifying errors and solving recurrent problems.

Avoiding errors continued:

Points to Ponder

WAYS TO PREVENT DRUG ADMINISTRATION ERRORS

PRECAUTION	RATIONALE
Read drug labels carefully.	Many products come in similar containers, colors and shapes.
Question administration of multiple tablets or vials for single dose.	Most doses are one or two tablets or capsules or one single-dose vial. Incorrect interpretation of order may result in excessively high dose.
Be aware of drugs with similar names.	Many drug names sound alike (e.g., digoxin and digitoxin, Keflex and Keflin, Orinase and Ornade).
Check decimal point.	Some drugs come in quantities that are multiples of one another (e.g., Coumadin in 2.5 and 25 mg tablets. Thorazine in 30 and 300 mg spansules).
Question abrupt and excessive increases in dosages.	Most dosages are made gradually so that physician can monitor therapeutic effect and response.
When a new or unfamiliar drug is ordered, consult resource.	If physician is also unfamiliar with drug, there is greater risk of inaccurate dosages being ordered.
Do not administer drug ordered by nickname or unofficial abbreviations.	Many physicians refer to commonly ordered medications by nicknames or unofficial abbreviations. If nurse or pharmacist is unfamiliar with name, wrong drug may be dispensed and administered.
Do not attempt to decipher illegible writing.	When in doubt, ask physician. Unless nurse questions order that is difficult to read, chance of misinterpretation is great.
Know individuals with same last name. Also have individuals state their full names. Check identification carefully.	It is common to have two or more individuals with same or similar last names. Special labels on Kardex or medication book can warn of potential problem.
Do not confuse equivalents.	When in a hurry, it may be easy to misread equivalents (e.g., milligram instead of milliliter).
Prepare medications under well lighted conditions.	Improves the ability to read labels accurately.
Check the expiration dates on drugs.	Ensures administration at desired potency.
Inspect the medication and reject those that appear to be decomposing in any manner.	Promotes appropriate absorption.

Avoiding errors continued:

Points to Ponder

MEDICATION/TREATMENT ERRORS AND OMISSIONS

NAME_____HOME/AGENCY_____
Date Error Discovered_____Time_____ByWhom_____
Medication or Treatment Involved

_____
_____
_____
_____

Description of Error in Detail (how discovered, effect on client, sequence of events, individuals involved)_____

_____
_____
_____
_____
_____
_____
_____

Name of Physician Notified_____Date & Time_____
By Whom_____
Physician's Instructions_____

_____
_____
_____

Physician's Signature _____Date & Time_____
Signature of Person Making Report_____Date & Time_____
Supervisor's Investigation_____

_____
_____
_____

Action Taken_____Date & Time_____

_____
_____
_____
_____

Signature of Supervisor_____Date & Time_____

Division of Mental Retardation

May 2002

Best Practice Guidelines

Infection Control

Special points of interest:

- General Guidelines for Infection Control
- Anticipated Outcomes
- Special Focal Points
- Points to Ponder

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Section I. Overview:

Many conditions and invasive procedures predispose individuals to infection either because the integrity of the skin or mucous membrane is altered or because an illness reduces the body's ability to summon additional defenses adequately against other invading microorganisms. Individuals with surgical incisions, artificial airways, catheters, intravenous lines, or implanted prosthetic devices, and those who continually have the skin broken by needle sticks for injections or the drawing of blood samples are at greater risk for infection and must be protected.

Infection control by methods of medical asepsis and universal precautions is a major factor in preventing the spread of infection. The other method of preventing the spread of infection is by the use of isolation procedures.

Infection control involves surveillance for signs of infection, immediate procedures to contain microorganisms when infection is evident, proper handling, sterilization or disposal of contaminated items and equipment, protection of individuals at high risk for infection, and prevention of nosocomial infections.

Infection control depends on knowing the mechanisms by which an infectious disease is transmitted and the methods that will interfere with the infectious process cycle. The single most important means of preventing the spread of infection is frequent hand washing. The process of increasing an individual's resistance to a particular infection by artificial means is called immunization.

Anticipated Outcomes of Infection Control

1. Infection does not spread to other body parts.
2. Proper handwashing.
3. Appropriate use of personal protective equipment.
4. Specific precautions for handling infectious material and sharps.
5. Procedures for routine disinfections of environmental surfaces and spills.

Section II. Course of infection:

An infection is a condition that results when microorganisms cause injury to their host. At one time contagious diseases, also called infectious or communicable diseases because they are spread from one person to another, were the leading cause of death. But because of the development of vaccines, implementation of aggressive public health measures, and advances in drug therapy, that is no longer the case. Nevertheless, contagious diseases have not disappeared.

I hope I don't get what he has. Why didn't he stay home?

Infections progress through distinct stages. The characteristics and lengths of each stage may differ depending on the infectious agent. Infection control depends on knowing the mechanisms by which an infectious disease is transmitted and the methods that will interfere with the infections process cycle.

INCUBATION PERIOD

There is an interval between entrance of the pathogen into the body and appearance of first symptoms (e.g., chicken-pox 2 to 3 weeks, common cold 1 to 2 days, influenza 1 to 3 days, and mumps 18 days). The infectious agent reproduces, but there are no recognizable symptoms. The infectious agent may, however, exit the host at this time and infect others.

PRODROMAL STAGE OF ILLNESS

Initial symptoms appear, they may be vague and nonspecific. There is an interval from the onset of nonspecific signs and symptoms (malaise, low-grade fever, and fatigue) to more specific symptoms; during this time, microorganisms grow and multiply. An individual is more capable of spreading disease to others.

FULL STAGE OF ILLNESS (ACUTE STAGE)

Symptoms become severe and specific to the tissue or organ affected. The individual manifests signs and symptoms specific to type of infection (e.g., common cold manifested by sore throat, sinus congestion, rhinitis. Mumps manifested by earache, high fever, parotid and salivary gland swelling. Tuberculosis is manifested by respiratory symptoms).

CONVALESCENCE

Acute symptoms of infection disappear; length of recovery depends on severity of infection and individual's general state of health; recovery may take several days to months. Health improves or is restored.

Points to Ponder

Chain of Infection

The presence of a pathogen does not mean that an infection will begin. Development of an infection occurs in a cyclical process that depends on the following elements: the infectious agent or pathogen, reservoir for pathogen growth, portal of exit from the reservoir, means of transmission or vehicle, portal of entry to host, and susceptible host.

Infection develops if the chain stays intact. The nurse's efforts to control infection are directed at breaking this chain.

Section III. Defenses against infection:

A. Normal defenses

Staying active, getting enough rest, and eating healthy help to fight against infection.

The body has normal defenses against infection. Normal flora, body system defenses, and inflammation are nonspecific defenses that protect against microorganisms, regardless of prior exposure. The immune system is composed of separate cells and molecules, some of which fight specific pathogens.

Normal Flora

The body normally contains large numbers of microorganisms that reside on the surface and deep layers of the skin, in saliva and oral mucosa, and in the intestinal walls. Normal flora do not cause disease but instead help to maintain health. The number of flora maintains a sensitive balance with other microorganisms to prevent infection. Any factor that disrupts this balance places an individual at serious risk for infection.

Body System Defenses

The skin, respiratory tract, and gastrointestinal tract are easily accessible to microorganisms, but they also have unique defenses against infection, physiologically suited to their structure and function. Any conditions that impair an organ's specialized defenses increase susceptibility to infection.

Inflammation

The body's cellular response to injury or infection is inflammation. Inflammation is a protective vascular reaction that delivers fluid, blood products, and nutrients to interstitial tissues in an area of injury. The process neutralizes and eliminates pathogens or neurotic tissues and establishes a means of repairing body cells and tissues. Signs of inflammation include swelling, redness, heat, pain or tenderness, and loss of function in the affected body part. When inflammation becomes systemic, other signs and symptoms develop; these include fever, leukocytosis, malaise, anorexia, nausea, vomiting, and lymph node enlargement.

Immune Response

When a foreign material (antigen) enters the body, a series of responses change the body's biological makeup so that reactions to future antigens are different from the first in an immune response, the antigen is neutralized, destroyed, or eliminated.

B. Types of precautions

Standard Precautions are used when caring for all individuals regardless of their infection status. Standard Precautions reduce the potential for transmitting blood-borne pathogens and those from moist body substances like feces, urine, sputum, saliva, wound drainage and other body fluids. They are followed whenever there is the potential for contact with: blood; all body fluids, secretions and excretions, regardless of whether they contain visible blood; nonintact skin; mucous membranes. They include Universal Precautions and Body Substance Isolation.

Transmission-Based Precautions, also called isolation precautions, are measures that are recommended for use in addition to Standard Precautions. Their purpose is to control the spread of infectious agents from persons with known or suspected transmissable pathogens. These include: Airborne Precautions; Droplet Precautions; Contact Precautions. These replace the previous categories of Strict Isolation, Contact Isolation, Respiratory Isolation, Enteric Precautions, and Drainage/Secretion Precautions. Transmission-Based Precautions may be required for various lengths of time depending on the nature of the infecting microorganism.

Defenses against infection continued:

C. Universal precautions

Health care workers are to wash their hands for 15-30 seconds using accepted facility procedures before and after each direct contact with an individual or the person's care items. Soap used should be from a dispenser or sponge scrub pad; bar soap is not acceptable. Handwashing is to be performed before donning gloves and after removing them. The sink, faucets, and paper towel dispenser are contaminated and should not be touched after handwashing. Only disposable towels are used for routine handwashing. Use a paper towel to turn off the water. If the towel dispenser requires that a crank be used to obtain the towel, dispense the towel prior to washing hands. Use a paper towel to open the exit door if needed. Dispose of used paper towels directly into the trash.

Singing the "Happy Birthday" song twice takes 30 seconds.

Handwashing is a vigorous, brief rubbing together of all surfaces of lathered hands, followed by rinsing under a stream of water. Push wristwatch and long sleeves above the wrists. Remove jewelry, except plain band, from fingers and arms. Keep fingernails short filed, and free of nail polish or artificial fingernails. Inspect surface of hands and fingers for breaks or cuts in skin and cuticles. Stand in front of sink, keeping hands and clothing away from sink surface. Avoid splashing water against clothing. Regulate flow of water so that temperature is warm. Hot water opens pores of the skin, causing irritation. Wet hands and lower arms thoroughly under running water. Keep hands and forearms lower than elbows during washing. Wash hands using plenty of lather and friction. Interlace fingers and rub palms and back of hands with circular motion at least 5 times each. Clean areas underlying fingernails. Rinse hands and wrists thoroughly, keeping hands down and elbows up. Repeat washing process if hands or nails are not clean. Dry hands thoroughly from fingers to wrists and forearms. Discard paper towel in proper receptacle. Turn off water using clean, dry paper towel.

D. Personal protective equipment

Gloves
Wear clean gloves when touching; blood, body fluids, secretions, excretions, and items containing these body substances; mucous membranes; nonintact skin. Follow facility policy.

Gowns
Nonpermeable gowns are to be worn when it is anticipated that the clothing may become soiled with blood or body fluids, including secretions and excretions. Gowns open in the back and fasten at the neck and waist. Follow facility policy.

Masks, Eye protection, Face shield
Wear a mask, eye protection, face shield during procedures and individual care activities that are likely to generate splashes or sprays of blood, body fluids, secretions, and excretions. Follow facility policy.

E. Sharps disposal

Sharp instruments (sharps) are placed directly into a special disposal container immediately after use. These containers shall be puncture resistant, labeled or color-coded, and leak proof on the sides and bottom. The sharp item should be dropped into the opening, and the fingers should never enter the mouth of the container. Never use fingers to push items down into a sharps container. Do not recap used needles. Never leave used, exposed IV needles hanging on the IV pole. All needles, IV cannulas, and items that are sharp or might cause a skin break are placed in the sharps container. Sharps containers should be replaced when they are three quarters full. Follow facility policy.

Section IV. When contamination occurs:

If blood or body fluids should come in contact with the nurse's body, follow facility policy and procedures to reduce contamination. The following are some suggestions.

Hands: Wash thoroughly with soap and water; use antimicrobial soap if available. Rinse or wipe with 70% isopropyl alcohol or a povidone-iodine solution after washing. If broken skin was involved, report to the employee health center or emergency room. An injury report must be completed when broken skin is involved.

Eyes: Flush immediately with large amounts of cool water. Report immediately to the employee health center or emergency room. An injury report must be completed.

Mouth or other mucous membranes: Rinse immediately with large amounts of water. Report to the employee health center or emergency room. An injury report is required.

Clothing: When clothing has become soiled by blood or body fluids, remove them and place them in a plastic bag for transport. Using gloves, treat blood stains with cold water and stain remover, then wash the items in the hot cycle with detergent. Use chlorine bleach if appropriate for the material. Clothing may also be dry cleaned but allow it to air out for 3 days so that viral agents will die before the clothing is taken to the dry cleaner.

Blood and body fluid spills: Spills are to be wiped up, using heavy gloves, with a freshly prepared 1:10 solution of chlorine bleach. A one minute contact time is necessary to kill HIV and other viruses. Know the correct solution to use for various spills or call the facility environmental health worker.

Nursing equipment: Wipe pens with alcohol swabs daily. Expose the blood pressure cuff to several hours of sunlight at least once a week; wash the cuff once a month or expose it to sunlight for a full 8 hours. Use only disposable covers on thermometers and otoscopes. Clean stethoscope, sphygmomanometer, or other equipment after use on an individual so pathogens are not transferred to the next individual.

Section V. Disposing of contaminated materials:

Various receptacles are used to hold and collect contaminated items. Soiled waste containers are emptied at the end of each shift or more often if their contents accumulate. To avoid spreading pathogens, some items are double-bagged. Follow existing facility policies.

Biodegradable trash is that which will decompose naturally into less complex compounds. Some items like uneaten food, paper tissues, the contents of drainage collectors, urine, and stool may be flushed down the toilet. Chemicals and filtration methods in sewage treatment centers are sufficient for destroying pathogens in human wastes.

Moist items such as soiled dressings, however, are wrapped so that during their containment pathogens cannot be transferred by flying or crawling insects. In some facilities, eventually the bag and its contents are destroyed by incineration, or they are autoclaved. Autoclaved items may be safely disposed of in landfills. In the home the soiled materials are to be placed in a small plastic bag, secured, then placed in the trash receptacle with a tight fitting lid for collection.

Section VI. Specimen collection techniques:

Follow facility policy and procedure regarding specimen collection and documentation. Nurses apply gloves when there is a risk of exposure to potentially infectious material. Specimens are delivered to the laboratory in sealed containers. The facility's infection control guidelines are followed as to whether the sealed containers are additionally bagged. When the testing is complete, most specimens are flushed, incinerated, or sterilized. Some suggestions for the collection of specimens may include:

Wound Specimen
Use cotton-tipped swab or syringe to collect as much drainage as possible. Have clean test tube or culturette tube on clean paper towel. After swabbing center of wound site, grasp collection tube by holding it with paper towel. Carefully insert swab without touching outside of tube. After securing tube's top, transfer into bag for transport and then wash hands.

Blood Culture Specimen
Use syringe and culture media bottles to collect 10 ml of blood per culture bottle. Perform venipuncture at two different sites to decrease likelihood of both specimens being contaminated with skin flora. Place blood culture bottles on bedside table or other surface, swab off bottletops with alcohol. Inject appropriate amount of blood into each bottle. Remove gloves and transfer specimen into clean bag for transport.

Stool Specimen
Use clean cup with seal top (not necessary to be sterile) and tongue blade to collect small amount of stool, approximately the size of a walnut. Place cup on clean paper towel in bathroom. Using tongue blade, collect needed amount of feces from the bedpan (if used). May also collect directly from the toilet if allowed by order of physician or laboratory. Transfer feces to cup without touching cup's outside surface. Dispose of tongue blade, wash hands, and place seal on cup. Transfer specimen into clean bag for transport.

Urine Specimen
Use syringe and sterile cup to collect 1-5 ml of urine. Place cup or tube on clean towel in bathroom. Use syringe to collect specimen if individual has a Foley catheter. Have the individual follow procedure to obtain a clean voided specimen if not catheterized. Transfer urine into sterile container by injecting urine from syringe or pouring it from used container. Wash hands and secure top of container. Transfer specimen into clean bag for transport.

Section VII. Documentation and teaching:

Document what you do.

Charting for the individual with problems of infection control should include noting the assessment date regarding the signs of infection and checking on flow-sheets the type of isolation procedures used each shift. Include the data regarding the course of the infection, the individual's response to the medical therapy for the infection, and any measures used to protect the individual from nosocomial infection.

Airborne Precautions are measures used to block very small pathogens that remain suspended in the air or are attached to dust particles. Droplet Precautions are measures used to block larger pathogens contained within moist droplets. Contact Precautions are used to block the transmission of pathogens by direct or indirect contact.

To prevent infections, the nurse can recommend that people (1) obtain appropriate immunizations, (2) practice a healthy lifestyle, and (3) avoid sharing personal care items. Unfortunately, symptoms of infectious disorders tend to be more subtle among older adults and individual's with chronic conditions.

Points to Ponder

RECOMMENDATIONS FOR PREVENTIVE HEALTH CARE:

Infancy Periodicity Table

AGE [5]	Prenatal [1]	Newborn [2]	2-4d [3]	By 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo
HISTORY Initial/Interval	•	•	•	•	•	•	•	•	•
MEASUREMENTS									
Height and Weight		•	•	•	•	•	•	•	•
Head Circumference		•	•	•	•	•	•	•	•
Blood Pressure									
SENSORY SCREENING									
Vision		S	S	S	S	S	S	S	S
Hearing		O [7]	S	S	S	S	S	S	S
DEVELOPMENTAL/ BEHAVIORAL ASSESSMENT [8]		•	•	•	•	•	•	•	•
PHYSICAL EXAMINATION [9]		•	•	•	•	•	•	•	•
PROCEDURES– GENERAL [10]									
Hereditary/ Metabolic Screening [11]		◄	•	►					
Immunizations [12]		•	•	•	•	•	•	•	•
Hematocrit or Hemoglobin [13]								•	►
Urinalysis [15]									
PROCEDURES– INDIVIDUALS AT RISK									
Lead Screening [16]								☼	►
Tuberculin Test [17]									☼
Cholesterol Screening [18]									
STD Screening [19]									
Pelvic Exam [20]									
ANTICIPATORY GUIDANCE [21]	•	•	•	•	•	•	•	•	•
Injury Prevention [22]	•	•	•	•	•	•	•	•	•
Violence Prevention [23]	•	•	•	•	•	•	•	•	•
Sleep Positioning Counseling [24]	•	•	•	•	•	•	•	•	•
Nutrition Counseling [25]	•	•	•	•	•	•	•	•	•
DENTAL REFERRAL [26]									►

KEY

- • = to be performed
- ☼ = to be performed for individuals at risk
- ◄► = the range during which a service may be provided, with the dot indicating the preferred age
- S = subjective by history
- O = objective, by a standard testing method

Points to Ponder

RECOMMENDATIONS FOR PREVENTIVE HEALTH CARE:

Early and Middle Childhood Periodicity Table

AGE [5]	15 mo	18 mo	24 mo	3y	4y	5y	6y	8y	10y
HISTORY Initial/Interval	•	•	•	•	•	•	•	•	•
MEASUREMENTS									
Height and Weight	•	•	•	•	•	•	•	•	•
Head Circumference	•	•	•						
Blood Pressure				•	•	•	•	•	•
SENSORY SCREENING									
Vision	S	S	S	O [6]	O	O	O	O	O
Hearing	S	S	S	S	O	O	O	O	O
DEVELOPMENTAL/ BEHAVIORAL ASSESSMENT [8]	•	•	•	•	•	•	•	•	•
PHYSICAL EXAMINATION [9]	•	•	•	•	•	•	•	•	•
PROCEDURES– GENERAL [10]									
Hereditary/ Metabolic Screening [11]									
Immunizations [12]	•	•	•	•	•	•	•	•	•
Hematocrit or Hemoglobin [13]	☼	☼	☼	☼	☼	☼			
Urinalysis [15]						•			
PROCEDURES– INDIVIDUALS AT RISK									
Lead Screening [16]			☼						
Tuberculin Test [17]	☼	☼	☼	☼	☼	☼	☼	☼	☼
Cholesterol Screening [18]			☼	☼	☼	☼	☼	☼	☼
STD Screening [19]									
Pelvic Exam [20]									
ANTICIPATORY GUIDANCE [21]	•	•	•	•	•	•	•	•	•
Injury Prevention [22]	•	•	•	•	•	•	•	•	•
Violence Prevention [23]	•	•	•	•	•	•	•	•	•
Sleep Positioning Counseling [24]									
Nutrition Counseling [25]	•	•	•	•	•	•	•	•	•
DENTAL REFERRAL [26]	◄	—	—	•					

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AAP Recommendations for Preventive Pediatric Health Care, Committee on Practice and Ambulatory Medicine

Points to Ponder

RECOMMENDATIONS FOR PREVENTIVE HEALTH CARE:

Adolescence Periodicity Table [4]

AGE [5]	11y	12y	13y	14y	15y	16y	17y	18y	19y	20y	21y
HISTORY Initial/Interval	•	•	•	•	•	•	•	•	•	•	•
MEASUREMENTS											
Height and Weight	•	•	•	•	•	•	•	•	•	•	•
Head Circumference											
Blood Pressure	•	•	•	•	•	•	•	•	•	•	•
SENSORY SCREENING											
Vision	S	O	S	S	O	S	S	O	S	S	S
Hearing	S	O	S	S	O	S	S	O	S	S	S
DEVELOPMENTAL/ BEHAVIORAL ASSESSMENT [8]	•	•	•	•	•	•	•	•	•	•	•
PHYSICAL EXAMINATION [9]	•	•	•	•	•	•	•	•	•	•	•
PROCEDURES– GENERAL [10]											
Hereditary/ Metabolic Screening [11]											
Immunizations [12]	•	•	•	•	•	•	•	•	•	•	•
Hematocrit or Hemoglobin [13]	◄	►	• [14]								
Urinalysis [15]	◄	►				• [15]					
PROCEDURES– INDIVIDUALS AT RISK											
Lead Screening [16]											
Tuberculin Test [17]	☼	☼	☼	☼	☼	☼	☼	☼	☼	☼	☼
Cholesterol Screening [18]	☼	☼	☼	☼	☼	☼	☼	☼	☼	☼	☼
STD Screening [19]	☼	☼	☼	☼	☼	☼	☼	☼	☼ [20]	☼	☼
Pelvic Exam [20]	☼	☼	☼	☼	☼	☼	☼	☼	◄ ☼	☼ ►	☼
ANTICIPATORY GUIDANCE [21]	•	•	•	•	•	•	•	•	•	•	•
Injury Prevention [22]	•	•	•	•	•	•	•	•	•	•	•
Violence Prevention [23]	•	•	•	•	•	•	•	•	•	•	•
Sleep Positioning Counseling [24]											
Nutrition Counseling [25]	•	•	•	•	•	•	•	•	•	•	•
DENTAL REFERRAL [26]											

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FOOTNOTES FOR PERIODICITY TABLES
INFANCY THROUGH ADOLESCENCE

1. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding per AAP statement "The Prenatal Visit" (1996).
2. Every infant should have a newborn evaluation after birth. Breastfeeding should be encouraged and instruction and support offered. Every breastfeeding infant should have an evaluation 48-72 hours after discharge from the hospital to include weight, formal breastfeeding evaluation, encouragement, and instruction as recommended in the AAP statement "Breastfeeding and the Use of Human Milk" (1997).
3. For newborns discharged in less than 48 hours after delivery per AAP statement "Hospital Stay for Healthy Term Newborns" (1995).
4. Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits.
5. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
6. If the individual is uncooperative, rescreen within 6 months.
7. All newborns should be screened per the AAP Task force on Newborn and Infant Hearing statement. "Newborn and Infant Hearing Loss: Detection and Intervention" (1999).
8. By history and appropriate physical examination: if suspicious, by specific objective developmental testing. Parenting skills should be fostered at every visit.
9. At each visit, a complete physical examination is essential, with infant totally unclothed, older children undressed and suitably draped.
10. These may be modified, depending upon entry point into schedule and individual need.
11. Metabolic screening (e.g., thyroid, hemoglobinopathies, PKU, galactosemia) should be done according to state law.
12. Schedule(s) per the Committee on Infectious Diseases, published annually in the January edition of *Pediatrics*. Every visit should be an opportunity to update and complete a child's immunizations.
13. See AAP *Pediatric Nutrition Handbook* (1998) for a discussion of universal and selective screening options. Consider earlier screening for high-risk infants (e.g., premature infants and low birth weight infants). See also "Recommendations to Prevent and Control Iron Deficiency in the United States." *MMWR*. 1998:47 (RR-3): 1-29.
14. All menstruating adolescents should be screened annually.
15. Conduct dipstick urinalysis for leukocytes annually for sexually active male and female adolescents.
16. For children at risk of lead exposure consult the AAP statement "Screening for Elevated Blood Levels" (1998). Additionally, screening should be done in accordance with state law where applicable.
17. TB testing per recommendations of the Committee on Infectious Diseases, published in the current edition of *Red Book: Report of the Committee on Infectious Diseases*. Testing should be done upon recognition of high-risk factors.
18. Cholesterol screening for high-risk individuals per AAP statement "Cholesterol in Childhood" (1998). If family history cannot be ascertained and other risk factors are present, screening should be at the discretion of the physician.
19. All sexually active individuals should be screened for sexually transmitted diseases (STDs).
20. All sexually active females should have a pelvic examination. A pelvic examination and routine Pap smear should be offered as part of preventive health maintenance between the ages of 18 and 21 years.
21. Age-appropriate discussion and counseling should be an integral part of each visit for care for the AAP *Guidelines for Health Supervision III* (1998).
22. From birth to age 12, refer to the AAP Injury Prevention Program [TIPP(r)] as described in *A Guide to Safety Counseling in Office Practice* (1994).
23. Violence prevention and management for all individuals per AAP statement "The Role of the Pediatrician in Youth Violence Prevention in Clinical Practice and at the Community Level" (1999).
24. Parents and caregivers should be advised to place healthy infants on their backs when putting them to sleep. Side positioning is a reasonable alternative but carries a slightly higher risk of SIDS. Consult the AAP statement "Changing Concepts of Sudden Infant Death Syndrome: Implications for Infant Sleeping Environment and Sleep Position" (2000).
25. Age-appropriate nutrition counseling should be an integral part of each visit per the AAP *Handbook of Nutrition* (1998).
26. Earlier initial dental examinations may be appropriate for some children, subsequent examinations as prescribe by dentist.

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Points to Ponder

RECOMMENDATIONS FOR PREVENTIVE HEALTH CARE:

Periodicity Table For 22 Through 49 Years

AGE	22	24	26	28	30	32	34	36	38	40	42	44	45	46	47	48	49
SUBJECTIVE																	
Update History	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
OBJECTIVE																	
Physical Exam (complete/interval)		•			•		•										
Height																	
Weight	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Blood Pressure	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Thyroid Exam	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Breast Exam 1	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Pelvic Exam 2	•	•	•	•	•	•	•	•	•	•	•	•		•		•	
Rectal Exam 3										•	•	•		•		•	
Oral Exam 4	•	•	•	•	•	•	•	•	•	•	•	•		•		•	
Skin Exam 5	•	•	•	•	•	•	•	•	•	•	•	•		•		•	
Ovaries Exam	•	•	•	•	•	•	•	•	•	•	•	•		•		•	
Testicles Exam 6	•	•	•	•	•	•	•	•	•	•	•	•		•		•	
Prostate Exam 7																	
Visual Screening										•	•	•		•		•	
Glaucoma Screen 8																	
Hearing Screening 9																	
LAB																	
Pap Smear 10	•	•	•	•	•	•	•	•	•	•	•	•		•		•	•
Mammography 11										•	•	•	•	•	•	•	•
PSA 12																	
Stool Occult Blood 13																	
Plasma Glucose 14																	
Sigmoidoscopy 15																	
Urinalysis 16																	
Hemoglobin 17																	
Cholesterol 18																	
IMMUNIZATIONS																	
Td 19																	
Influenza 20																	
Pneumococcal 21																	
Hepatitis B 22																	
MMR 23																	
PPD 24																	

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Points to Ponder

RECOMMENDATIONS FOR PREVENTIVE HEALTH CARE:

Periodicity Table for 50 Years and Older

AGE	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70+
SUBJECTIVE																					
Update History	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
OBJECTIVE																					
Physical Exam (complete/interval)	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Height																					
Weight	•		•		•		•		•		•		•		•	•	•	•	•	•	•
Blood Pressure	•		•		•		•		•		•		•		•	•	•	•	•	•	•
Thyroid Exam	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Breast Exam 1	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Pelvic Exam 2	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Rectal Exam 3	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Oral Exam 4	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Skin Exam 5	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Ovaries Exam	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Testicles Exam 6	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Prostate Exam 7	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Visual Screening	•		•		•		•		•		•		•		•		•		•		•
Glaucoma Screen 8											•		•		•		•		•		•
Hearing Screening 9																•		•		•	
LAB																					
Pap Smear 10	•		•		•		•		•		•		•		•		•		•		•
Mammography 11	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
PSA 12																					
Stool Occult Blood 13	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Plasma Glucose 14																					
Sigmoidoscopy 15	•		•		•		•		•		•	•	•		•		•		•		•
Urinalysis 16																					
Hemoglobin 17																					
Cholesterol 18																					
IMMUNIZATIONS																					
Td 19																					
Influenza 20																•	•	•	•	•	•
Pneumococcal 21																•					
Hepatitis B 22																					
MMR 23																					
PPD 24																					

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Points to Ponder

FOOTNOTES FOR PERIODICITY TABLES
AGE 22 THROUGH 49 YEARS AND AGE 50 AND OLDER

1. **Breast Exam (women):** Annual examination. Increased frequency if first-degree relative has had breast cancer diagnosed before menopause.
2. **Pelvic Exam (women):** Baseline screening at 18 years of age (before if sexually active), and annually for next two years. If results of all three exams are negative, then screen every two years until age 50 and annually 50 years of age and older. Annual exam recommended if on birth control method or exhibiting high risk behaviors.
3. **Rectal Exam:** Annually if family history of prostate cancer, otherwise baseline at 40 years of age and then every 2 years to age 50; annually 50 years of age and older. Begin annual screening at 35 years of age if either a family history of colorectal adenomatous polyps, cancer in one or more first-degree relatives, or personal history of adenomas or inflammatory bowel disease.
4. **Oral Exam:** Give special attention to persons at high risk due to tobacco and alcohol use, or those of lower socioeconomic status.
5. **Skin Exam:** High risk persons include those with a family or personal history of skin cancer, increased occupational or recreational exposure to sunlight, or clinical evidence of precursor lesions (e.g., dysplastic nevi and certain congenital nevi).
6. **Testicular Exam (men):** High risk persons have a history of cryptorchidism, testicular atrophy, ambiguous genitalia.
7. **Prostate Exam (men):** Annual screening for men 40 to 49 years of age who have a family history of prostate cancer, and for all men over 50.
8. **Glaucoma Screening:** Refer high risk persons (those with family history of glaucoma, diabetes, or severe myopia) to ophthalmologist. Prevalence of glaucoma is higher in African Americans over 40 and in Caucasians over 65 years of age. Frequency of screening in these populations is determined by clinical judgement.
9. **Hearing Screening:** Those persons exposed regularly to excessive noise (e.g., in recreational or occupational settings), should be screened every one to three years. Persons 65 years of age and over should be screened every two years.
10. **PAP Smear (women):** following three negative screenings, screen every two years, or as determined by clinical judgement.
11. **Mammography (women):** Baseline at 40 years of age and thereafter annually. Begin annual screening at 35 years of age if either a first-degree relative has had breast cancer diagnosed before menopause, or there is a family history of bilateral breast cancer.
12. **Prostate Specific Antigen (men):** Routine screening for asymptomatic persons is not recommended. At present the lack of evidence regarding benefits of prostate screening and the considerable risks of treatment complications make it important for persons to be referred to a physician for additional counseling.
13. **Stool Occult Blood:** Annual screening for all persons 50 years of age and older. Begin screening at 40 years of age if high risk, i.e., first degree relative with colorectal cancer, personal history of endometrial, ovarian, or breast cancer; previous diagnosis of inflammatory bowel disease, adenomatous polyps, or colorectal cancer; or family history of familial polyposis or cancer family syndrome.
14. **Fasting Plasma Glucose:** Routine screening for asymptomatic persons is not recommended. Clinicians may decide to screen selected persons at high risk of NIDDM who include obese men and women over 40, persons with a strong family history of diabetes, and members of certain ethnic groups (Native Americans, Hispanics, African Americans); the frequency of screening is according to clinical discretion. Clinicians may decide to screen high-risk pregnant women. Risk factors include obesity, older maternal age, family history of diabetes, and a history of macrosomia, fetal malformations, or fetal death.
15. **Sigmoidoscopy:** Beginning at age 50 and thereafter every 3 to 5 years based on advice of physician. Begin screening at 40 years of age if high risk, i.e., first degree relative with colorectal cancer; personal history of endometrial, ovarian, or breast cancer; previous diagnosis of inflammatory bowel disease, adenomatous polyps, or colorectal cancer; family history of familial polyposis or cancer family syndrome.
16. **Urinalysis:** Screen for asymptomatic bacteriuria with urine culture is recommended for pregnant women at 12-16 weeks gestation. Subsequent periodic urine cultures during pregnancy is left to clinical discretion. Routine screening for bacteriuria with leukocyte esterase or nitrite testing is not recommended for other asymptomatic adults.
17. **Hemoglobin or Hematocrit:** Screen all **non-pregnant women** every 5-10 years until menopause. Screen **high risk women** annually (extensive menstrual/other blood loss, low iron intake, previous diagnosis of iron-deficiency anemia).
18. **Cholesterol:** Screen every 5 years in men 35-65 and in women 45-65. Those >65 with major CHD risk factors (smoking, hypertension, diabetes) may benefit from screening and interventions.
19. **Td:** Follow current immunization recommendations.
20. **Influenza:** Annual immunization is recommended for any person at increased risk for complications of influenza. Target groups include all persons 50 years of age or older, persons any age that have a chronic illness (lungs, cardiovascular, diabetes, renal, immunosupression), those persons receiving long-term aspirin therapy, and women who will be in the second or third trimester of pregnancy during the influenza season. Immunization is also recommended for individuals who may transmit influenza to persons at increased risk, such as health-care workers and household members.
21. **Pneumococcal Vaccine:** Immunize once all people 65 years of age and older. Also immunize once at any age persons who are immunocompromised, and those with chronic illness, e.g., cardiovascular disease, pulmonary disease, diabetes mellitus, alcoholism, cirrhosis.
22. **Hepatitis B:** Immunize, or advise of the need for immunization, those individuals in groups at increased risk for HBV infection, i.e., health care workers and others at occupational risk; hemophiliacs and other recipients of certain blood products; household contacts and sex partners of HBsAg positive persons; hemodialysis patients; injection drug users; sexually active homosexual or bisexual males.
23. **MMR:** Immunize persons who were born after 1957 and who have not received immunizations for measles, mumps, and rubella.
24. **PPD:** Follow current recommendations in Tuberculosis Guidelines for routine screening and high-risk populations.

Points to Ponder

TEACHING FOR PREVENTING INFECTIONS

Teach the individual and caregivers to do the following:

- Bathe daily and perform other forms of personal hygiene such as oral care.
- Keep the home environment clean and uncluttered.
- Use diluted household bleach (1:10 or 1:100) as a good disinfectant.
- Obtain appropriate immunizations; tetanus vaccine is recommended at 10-year intervals, the influenza vaccine must be repeated yearly, and a pneumococcal pneumonia immunization is recommended.
- Practice a healthy lifestyle such as eating the recommended servings from the food pyramid.
- Maintenance of an adequate fluid intake promotes normal urine formation and a resultant outflow of urine to flush the bladder and urethral lining of microorganisms.
- Perform frequent handwashing, especially before eating and after contact with nasal secretions and use of the toilet.
- Use and immediately discard disposable tissues rather than reuse a cloth handkerchief.
- Avoid sharing personal care items like washcloths, towels, razors, and drinking cups.

- Stay home from work, school, or day programs when ill rather than expose others to infectious pathogens.
- Relieve an ill caregiver from the responsibility of cooking meals.
- Keep food refrigerated and heat it thoroughly when preparing food for consumption.
- Avoid crowds and public places when there are local outbreaks of influenza.
- Follow infection control instructions when visiting hospitalized family members, roommates, and friends.
- Comply with drug therapy when prescribed.
- For physically dependent or immobilized individuals, provide frequent position changes to decrease the risk of skin breakdown at bony prominences.

- For physically dependent or immobilized individuals, encourage routine coughing and deep breathing to keep lower airways clear of mucus.
- Promote an individual's comfort and sleep so that energy stores are replaced daily.
- Teach the application of aseptic principles to self-care activities such as wound care and medication administration.

Points to Ponder

Focus on Older Adults and Those with Chronic Illnesses

Symptoms of infections tend to be more subtle among older adults and those with chronic illness, but infections are more likely to have a rapid course once one becomes established.

Confusion and changes in behavior are often signs of infection.

Healing takes longer in the elderly person.

Chronic diseases reduce the older person's ability to resist infections.

Elderly individuals have thin skin and often have skin breaks or tears. Proper handwashing is vitally important before working with these individuals to prevent nosocomial infection.

The older individual, especially if in a weakened condition, may need assistance with nail care.

All elderly individuals are at higher risk for infection than is the general population because immune function declines with age.

Many elderly individuals have a poor nutritional status, which places them at higher risk for infection.

Older adults are more susceptible to infectious diseases because they have decreased lymphocyte cells and a decreased antibody response.

Chronic diseases, such as impaired circulatory function or diabetes, may contribute to a higher risk for infections.

Individuals with chronic aspiration and recurrent pneumonia are at a higher risk for infections. Pneumonia is the fourth leading cause of death among older adults, whereas influenza is the fifth leading cause of death in people older than 65 years of age.

Recognizing an infectious process early may prevent the necessity for admitting individuals to an acute care setting.

Individuals who are cognitively impaired may not comply with infection control measures.